REDACTED

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAMODARA RAJASEKHAR, M.D. 18182 Outer Highway 18, #103 Apple Valley, CA 92307 Physician's and Surgeon's Certificate No. A 55917 Respondent.	Case No. 09-1999-96986 OAH No. L2002040150

DECISION AFTER RECONSIDERATION

On June 23, 2003, in San Diego, California, and on June 24-26, 2003, and January 27, 2004, in Riverside, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Mary Agnes Matyszewski, Deputy Attorney General, represented complainant.

Jeffrey G. Keane, Attorney at Law, represented respondent.

The matter was submitted on January 27, 2004.

On February 18, 2004, the Administrative Law Judge submitted his proposed decision. Thereafter, the Division of Medical Quality adopted said proposed decision and issued an Order of Adoption to become effective May 14, 2004.

Thereafter, complainant petitioned for reconsideration. Reconsideration was granted for the limited purpose of reconsidering Legal Conclusion 9 of the Decision regarding Business and Professions Code section 2234(c), "repeated negligent acts." The Order Granting Reconsideration also included a stay of execution.

Panel B of the Division of Medical Quality has reviewed the Petition for Reconsideration and the written argument filed by both parties, heard oral argument on November 4, 2004, and now makes and enters its Decision After Reconsideration as follows:

FACTUAL FINDINGS

1. On August 7, 2000, Ron Joseph, Executive Director, Medical Board of California (Board), filed Accusation No. 09-1999-96986 in his official capacity. Respondent filed a timely Notice of Defense. Complainant filed a First Amended Accusation on August 26, 2003, and an Amendment to the First Amended Accusation on October 25, 2003. The accusation centers upon respondent's care and treatment of two infants during 1998 and 1999.

2. On April 3, 1996, the Board issued Physician's and Surgeon's certificate No. A 55917 to respondent.

3. Respondent is 52 years of age. He attended the University of Madras, India, receiving a bachelor's degree in zoology in 1969 and his medical degree in 1976. He became a Diplomate in Child Health in 1978 after two more years of post-graduate work at the University of Madras. He taught pediatrics for a year and in 1979, he went to the New Medical Center in Abu Dhabi, United Arab Emirates, where he served as an attending physician in ambulatory pediatrics. He remained there for seven years, until he moved to the United Kingdom and began working in a series of national health hospitals in pediatrics and neonatology.

Respondent came to the United States in 1990 and did a one-year residency in pediatrics at the University of Connecticut. He became board certified in pediatrics in 1991 and began a fellowship in neonatal-perinatal medicine at the University of Massachusetts. He remained there for three years, until he moved to Kentucky, where he became chairman of the Department of Pediatrics and the Credentials Committee at the Mary Breckinridge Hospital in Hyden.

Respondent began a solo practice in pediatrics and neonatology in Apple Valley, California, in 1996. In 1997, he became board certified in neonatology, and in 1998, was recertified in pediatrics. About 15 percent of his practice is neonatology, and the rest is pediatrics. He is the only board certified neonatologist in the high desert. He is on staff at St. Mary's Hospital and Victor Valley Community Hospital, and is presently the Chief of Medical Staff at Victor Valley. He is serving as a board member and delegate of the California Medical Association-Organized Medical Staff Section and had attended AMA meetings as a CMA delegate.

Respondent's practice has not changed much over the years. He sees children for well child care, including physical examinations and shots, and sick visits. He has one medical assistant for the back office and another assistant who makes appointments and answers the phone. The medical assistant must prepare the chart, notes the complaints as related by the mother and records them, and takes vital signs and records them. Respondent has four examining rooms, and regularly uses three of them at a time.

4. Kristin S. was born on [redacted] at St. Mary's Regional Medical Center in

Apple Valley, and respondent became her pediatrician. Her mother first brought her to respondent's office on June 30. At that time, her mother completed a New Patient Questionnaire, and in response to the question "Are there any smokers in the household?" her mother circled "No." That answer was false, because she and her husband did smoke. The St. Mary's Obstetric Admitting Record indicates Kristin S.' mother did smoke, but it was not established that respondent ever saw this record. At some point during the ensuing seven months, respondent learned Kristin S.' mother smoked.

The visit on June 30, 1998 was a two-week well baby check. Kristin S.' mother informed the medical assistant there were bumps on the baby and she had been coughing, sneezing, and had a loss of appetite for three days, and that information was recorded on the progress note routinely completed at the time of an office visit by respondent and his medical assistant. The infant's mother told respondent she was breast feeding and the baby had been fussy for the last two days.

Respondent's well baby examinations include checking how the baby looks, moving its hands and legs, checking its color, examining its head, mouth, eyes, throat, ears, neck, listening to its heart and lungs, examining the abdomen, hips and ankles, checking its strength, and making sure if its testes have descended if the baby is a boy. Respondent's examination of Kristin S. revealed only congestion and an atopic rash. His diagnosis was upper respiratory infection (URI) because of the sneezing and coughing and atopic rash, and his plan was to treat the child with saline nasal drips. He gave her a routine hepatitis B injection and told her mother to return if the symptoms persisted.

Kristin S.' mother brought her baby back to respondent's office on July 27. This was a sick baby visit, and the mother reported to the medical assistant that Kristin S. had a runny nose, was coughing and was irritable for two days, bowel movements were not regular, and she was breast feeding all day. Her mother told respondent the baby had a cough and cold for one day, the baby was fussy but there had been no vomiting or diarrhea, bowel movements were irregular, breast milk was not adequate, and she herself had flu symptoms for the last few days. Respondent noted the baby had gained less than a pound since the last visit. He found everything within normal limits except for congestion, diagnosed URI, and recommended saline nasal drops and supplemental feeding.

The next visit took place on August 21. It was a new baby visit and there were no complaints. Respondent's examination revealed growth and development within normal limits, and gave her the scheduled injections.

The next visit on October 6 was a sick baby visit. Kristin S.' mother told respondent's medical assistant she had taken Kristin S. to the Emergency Room two weeks before for tonsillitis and was given amoxicillin, the baby still had some symptoms including coughing, the medications were not working, and there was an ear infection with drainage from her right ear. Kristin S.' mother repeated this information to respondent except for the ear drainage, and added the cough and congestion persisted, but there was no fever. The baby's temperature at the time of the visit was 99.3. Respondent found her throat was red (erythematous) and after examining her ears and chest, found they were clear. He diagnosed

URI and prescribed Benadryl because there was a history of allergies in the family.

Kristin S.' mother brought the child back to respondent's office on December 10 for a sick visit because of a cold and coughing, and a low grade fever. The mother reported one of her siblings may have put a Q-tip in her ears. A temperature taken in the office was 99.2. Respondent found the child's throat was red, and her ears and chest were clear. He again diagnosed URI, but this time prescribed amoxicillin, along with Benadryl and Tylenol as needed.

Kristin S.' last visit to respondent's office occurred on February 3, 1999 and was a sick baby visit. It took place late in the afternoon. The complaints as related to the medical assistant included a temperature of 102, congestion, coughing and runny nose for three days. The child's pulse and temperature taken in the office were normal. Kristin S.' mother told respondent the baby had been fussy for three days, had a fever for two days, had a cough and cold for three days, had vomited the day before but did not have diarrhea, and her appetite had decreased. Respondent's examination revealed her throat was red, her ears were fine, and there were scattered rhonchi. He diagnosed URI based on the runny nose and bronchiolitis based on the rhonchi. Respondent's office note indicates his plan was for the baby to take ventolin liquid, Tylenol and Benadryl. He also noted he would check for respiratory syncytial virus infection (RSV) and have a chest x-ray done. He sent Kristin S.' mother next door to St. Mary's lab to have the chest x-ray and RSV test performed. Respondent's chart note indicates he told the mother to call him if symptoms persisted.

Kristin S.' mother took her child to the lab for a chest x-ray and a nasopharyngeal RSV test. The radiologist read the chest x-ray on February 4 and reported it was normal. He reported "No lung consolidation is seen. . . The pulmonary vessels appear normal." The Board's expert noted the chest x-ray did not show any hyperinflation or flattened diaphragms which are diagnostic of moderate bronchiolitis.

The RSV test was positive and the results were reported to respondent at 7:45 p.m. on February 3. Respondent did not call Kristin S.' parents to advise them of the test results.

5. Kristin S.' parents took her home from the hospital and gave her Benadryl and the saline drops. She fell asleep in her mother's lap around 9:00 p.m. Her mother moved her onto the sofa, and let her sleep there through the night, while her parents went to bed. They did not check on her during the night. When her father checked her around 8:00 a.m., he found she was not breathing. Paramedics took her to St. Mary's Hospital where Dr. Dennis Wheeler of the Emergency Department saw her at 8:50 a.m. in full cardiopulmonary arrest. A chest x-ray taken in the emergency department revealed possible perihilar infiltrates typical of RSV bronchiolitis. The child never demonstrated any cardiac activity and was pronounced dead at 9:04 a.m. Dr. Wheeler's impression was SIDS associated with a non-lethal respiratory problem.

6. Dr. Frank Sheridan, a pathologist, performed an autopsy on Kristin S. on February 9. Regarding the respiratory tract, Dr. Sheridan found marked erythema of the epiglottis, and erythema of the mucosa of much of the trachea, no foreign material in the

airway, and generalized congestion and equivocal consolidation particularly in the right lower lobe of the lungs. Microscopic examination of the respiratory tract revealed dense chronic inflammatory cell infiltrates in the submucosa of the larynx, bronchi, and bronchioles, extending focally into the pulmonary interstitium, and early focal alveolar consolidation. Dr. Sheridan's diagnosis was respiratory syncytial virus infection (RSV), based on positive clinical testing, epiglosottis, laryngitis, tracheitis, and bronchitis, and bronchiolitis with early penumonitis. He designated the cause of death as upper and lower respiratory tract infection, days, due to RSV, days.

7. RSV is a common respiratory virus that attacks children usually under the age of three. About 70 percent of children under the age of one have had it, and almost every child under the age of two has had it. It is seasonal, usually attacking in the winter and in particular infecting young infants. It has a propensity to infect the lower bronchi. Its symptoms can range from an upper respiratory infection with mild symptoms like sniffles to severe pulmonary disease with respiratory distress, fast breathing, a fast heart rate, or audible wheezing in the lungs. It may lead to edema of the smaller air tubules in the respiratory tract and it can attack the heart causing arrhythmias. There is an increased risk for RSV if the child is premature, has congenital heart disease, or is exposed to second-hand smoke.

8. To support the allegations of incompetence and repeated negligent acts set forth in the first amended accusation, complainant called Dr. Joseph Carella. He attended Tufts University Medical School, graduating in 1965 and completed his internship and residency there. He is board certified in pediatrics. He served in the Navy for two years and then worked for a year in an emergency room. He opened his own private pediatric practice in 1972, and kept it until 1984, at which time he did a year of missionary work in Swaziland, Republic of South Africa. Since his return to the United States, he has been in what he called semi-private practice, with much of his work in various children's homes relating to abused children. He has reviewed three or four cases a year for the Board and is an assistant professor of pediatrics at UCI.

Dr. Carella reviewed respondent's chart and other relevant information, and concluded respondent's care and treatment of Kristin S. was negligent and incompetent. He criticized respondent for failing to obtain a respiratory rate to determine if there was lower respiratory tract involvement and for failing to note the color of the patient or whether she was in distress. He testified the standard of care required respondent to obtain a respiratory rate and respondent's failure to obtain it was a simple departure from the standard of care and demonstrated incompetence. He suspected Kristin S. was breathing fast and her breathing may have been compromised because she was not feeding well and was wheezing, and if that was the case, she should have been hospitalized.

Dr. Carella testified respondent's failure to obtain a pulse oximeter reading to measure the amount of oxygen in the child's blood was also a simple departure from the standard of practice. A lower oxygen level would show the lungs were compromised, and the lower the level, the more likely the child would be hospitalized. He felt if respondent believed there was sufficient reason to order an RSV test and chest x-ray, then a pulse oximeter test should also have been performed. Respondent had a pulse oximeter in his

office. He suspected, however, Kristin S. was not that severely compromised because respondent did not admit her directly into the hospital but instead sent her to the hospital for testing.

Dr. Carella also believed respondent had a moral obligation and should have notified Kristin S.' parents that the RSV test was positive. He based this conclusion on a statement by Kristin S.' mother that respondent had told her he would call her and tell them the results of the test, and admit the child if she was positive for RSV. Dr. Carella believed respondent should then have obtained more information about the child, including her feeding.

Because respondent knew there was smoking in the home, according to Dr. Carella, respondent should have been more thorough and complete, and have a higher index of suspicion. He felt respondent should also have been aware of other risk factors for RSV, including lower socioeconomic environments, less maternal education, school aged siblings, birth during RSV season, but he acknowledged that there were mitigating factors such as the child was older than six months, she was not premature, and she did not have chronic pulmonary disease to T-cell defects. Based on all these facts, he felt respondent should have taken extra precautions to include monitoring the respiration rate and pulse oxymetry and feeding patterns, and ensure there were not other complications from the RSV. In his opinion, these failures revealed a lack of clinical judgment and knowledge.

It was Dr. Carella's opinion that Kristin S. had a pan respiratory RSV infection which may have been the trigger for a SIDS event.

9. Dr. Robert Hamilton testified on behalf of respondent relating to the Kristin S. allegations. He is a general pediatrician with a private practice in Santa Monica. He is board certified in pediatrics. He attended the UCLA Medical School and did his internship and residency there. He is an assistant clinical professor of pediatrics at UCLA and an instructor in pediatrics at Western University School of Medicine in Pomona. He is the vice-chair of the Department of Pediatrics at St. Johns Health Center, a member of the Pediatric Committee and a clinical instructor of pediatrics at UCLA/Santa Monica Hospital, and a clinical instructor of pediatrics at Cedars-Sinai Hospital.

Dr. Hamilton reviewed respondent's records and other relevant information relating to his care and treatment of Kristin S., and concluded respondent did not violate the standard of care and was not incompetent. He agreed with Dr. Carella the cause of the child's death was probably SIDS.

Dr. Hamilton pointed out the record did not disclose Kristin S. was suffering from respiratory distress. The record disclosed a history of coughing and runny nose, but there were never any reports of difficulty in breathing. He pointed out it may be difficult to obtain a respiratory rate in children because they are frequently crying or fussing, but a doctor can easily see if a child is having difficulty breathing. He noted there was no evidence respondent ever observed the child panting or flaring her nose or grunting or exhibiting retractions of her ribs, for instance, or showing any other sign that she was having difficulty breathing. He felt such signs were more important than a number.

Dr. Hamilton testified the treatment for RSV depended on the level of illness, and noted younger children (under two months) were more affected by the virus. For a child to be hospitalized with RSV, there must be significant respiratory distress and an elevated temperature. In fact, a significant clinical picture even without a positive RSV test would probably require hospitalization, while a positive RSV test without an accompanying clinical picture does not require hospitalization. He also noted Kristin S. presented in February, which is a peak time for RSV. He felt that based on what respondent heard, he was justified in ordering a chest x-ray and giving her ventolin, a bronchodilator, but because she was afebrile and did not present as being in respiratory distress, but rather having mild to moderate respiratory problems, respondent's decision to order a chest x-ray was an indication of him being thorough and conservative, and his intuition proved correct.

In Dr. Hamilton's opinion, it was not below the standard of care for respondent to send Kristin S. for an RSV test and ask the parents to monitor her and call him, or call him for the results of the test. He testified respondent prescribed medications to make the child comfortable, she was afebrile and not in any significant distress when she went home, and therefore, he was justified in telling them to call him if anything occurred. Dr. Hamilton pointed out the normal chest x-ray meant there was no significant respiratory involvement such as a flattening of the diaphragm, and did not require any action that night because the child was not in any immediate danger. He felt that respondent speaking to the parents in the morning and reassessing the child either in his office or over the phone was appropriate.

Dr. Hamilton testified that at this time, a pulse oximeter reading in this situation is the standard of care, but was not the standard of care in 1999. He testified that not many doctors even had pulse oxymenters then, and it would have been very aggressive to send a patient to a hospital emergency room to have the oxygen level checked. He felt it would have been nice to have the oxygen level, but was not required in the absence of any evidence the child was not getting enough oxygen, and was not below the standard of care for respondent not to check Kristin S.' oxygen level even if he had a pulse oximeter in his office.

Dr. Hamilton read the depositions of Kristin S.' parents taken in connection with a civil case, and noted they did not show any panic or concern. He indicated they did not report any temperature elevation or difficulty in their child's breathing, they did not call respondent, and they did not take Kristin S. to an emergency room as they had done in the past. They went to bed, while leaving Kristin S. on a couch, and they made no effort to check her during the night. Based on this, he concluded Kristin S. appeared all right and was not acutely ill from the RSV such that it would have caused her death. In his experience, RSV proceeded slower. Indeed, the autopsy showed the RSV did not affect her airway and did not obstruct her breathing.

10. Desiree D. was born on [redacted] at St. Mary's Regional Medical Center, and respondent became her pediatrician. Her mother had received no prenatal care, and did not even know she was pregnant until shortly before she delivered. The mother's urine screen was positive for amphetamines as was the baby's. Based on that, respondent ordered social services to be notified.

Desiree D.'s first visit to respondent's office took place on November 17, 1998. It was a well baby visit and she was brought in by her parents. The child's weight was appropriate. Respondent found her growth and development were within normal limits and indicated she was doing well. Her two-month old visit on December 29 was likewise normal. The baby had gained two pounds since her previous visit. Respondent gave her routine shots on each of the first two visits.

The next visit, on February 1, 1999, occurred because Desiree D. was sick. Desiree D. had gained more than a pound since her last visit. Her mother reported white bumps on her tongue and she spit up a lot. Respondent noted the mother said Desiree D. had white lesions in the mouth for two days but was feeding all right. Respondent's examination revealed oral thrush, and everything else was within normal limits. Thrush is a common fungal skin and mucous membrane infection. It does not have symptoms, interfere with feeding or cause weight loss, or cause fever or respiratory compromise, and is characterized by white plaques in the mouth, tongue, or gums, or a rash. Respondent prescribed Nystatin oral suspension and cream.

Desiree D.'s mother brought the baby back to respondent's office ten days later because she was coughing, congested, the thrush was still there, and she had lost weight. Comparing her weight on this visit to her previous visit shows a nine ounce weight loss. She did not have a fever and her mother reported none. Respondent found the oral thrush was extensive, that is, there was more than previously. He diagnosed oral thrush and URI. He changed the medication to gentian violet for thrush and also prescribed Dimetapp.

Desiree D.'s last visit to respondent's office occurred on March 4, 1999. She was brought in by her parents who told the medical assistant in part: "bruised cheeks, unknown reasons x 1 ½ wks—thrush still prominent, hoarse voice." She had lost two ounces since her last visit. Respondent recorded the parents told him she had had a fever for two days, the oral thrush was still there, there had been no vomiting or diarrhea, and "injury face due to falling toy 1 wk ago, feeding well." Respondent found the baby's throat was red, her ears and chest were clear, and he recorded "Bruised over rt. cheek area—fading." His diagnosis and plan were URI and oral thrush to be treated with amoxicillin, and Tylenol.

11. Desiree D. arrived at the St. Mary's Regional Medical Center emergency room at 4:40 p.m. on March 9, 1999 in full cardiac arrest. Paramedics performed CPR while in route to the hospital. According to the family's report, she was found lying down, cyanotic, and not breathing. Dr. Fletcher, the emergency room doctor who treated Desiree D., found she had no spontaneous respirations, blood pressure, or pulse. She noted bruising around the mouth and cheek area and under the chin and left ear. She found multiple areas of bruising about the face, frontal region, and left hip. Desiree D. was transported to Loma Linda University Pediatric ICU by life flight in critical condition.

Doctors at Loma Linda University determined on March 10 that Desiree D. was brain dead caused by a non-accidental trauma. Desiree D. was removed from a ventilator and she was pronounced dead at 12:01 p.m. The final diagnosis was fatal child abuse, with bilateral

retinal hemorrhages, subdural hemorrhages, multiple rib fractures of varying ages, multiple long bone fractures including a metaphysical fracture, human bite marks, and multiple bruises of varying ages noted.

12. Dr. Sheridan performed an autopsy on Desiree D. on March 12, 1999. He determined the cause of death to be shaken baby syndrome with significant findings of chronic physical abuse. The diagnosis of shaken baby syndrome was supported by evidence of fresh subdural hematoma, fresh bilateral optic nerve sheath hemorrhage and retinal hemorrhage, diffuse axonal injury with cerebral edema, and early bronchopneumonia. The evidence of chronic physical abuse consisted of multiple cutaneous blunt force injuries of varying ages, bite marks on the left leg and left buttock, a tear of the frenulum of the upper lip which was healing, multiple left-sided rib fractures which were healing and acute, multiple long bone metaphyseal fractures of the upper and lower extremities which were healing, and microscopic evidence of old subdural and optic nerve sheath hemorrhage. Dr. Sheridan commented the baby died as a result of a head injury due to violent shaking.

13. Respondent learned Desiree D. had been taken to St. Mary's and ordered a skeleton survey be performed. Dr. Bernard Hindman, a radiologist at Loma Linda University Medical Center, reviewed chest and abdominal radiographs taken on March 9 at St. Mary's and a bone survey performed at Loma Linda on March 10. He found multiple healed left rib fractures and a right posterior 10th rib fracture. The fracture line was consistent with early healing. There were healing fractures in the distal left femur, proximal right tibia, distal left tibia and fibula, and the distal radius bilaterally which was almost completely healed. He found soft tissue swelling adjacent to the healing fractures of the distal right radius and in the left ankle, suggesting a fracture two to three weeks old, perhaps less. The fractures in the distal left femur and posterior right 10th rib also appeared to be two to three weeks old, but he was less certain about the ages of those fractures than the ages of other fractures. He felt the fractures of the distal left radius and proximal right tibia were four to six weeks old. He could not determine the age of skull separation. He believed the fractures that were two to three weeks old should have been apparent symptomatically at the time of respondent's examination in March, and the older fractures should have been apparent symptomatically at the February visits.

14. The accusation alleges respondent was grossly negligent and incompetent and committed repeated negligent acts in his care and treatment of Desiree D. Dr. Carella served as complainant's expert and believed the evidence supported the charges.

Dr. Carella explained weight loss beginning with the February 11 visit was significant. By the March 4 visit, Desiree D. should have gained more than a pound and a half in light of the history related to him by her mother on March 4 that the infant was "feeding well." Instead, the infant lost nine ounces in the ten days between February 1 and February 11, and another two ounces during the ensuing three weeks. In addition, one of the mother's chief complaints on February 11 was weight loss. In Dr. Carella's, view, this was a red flag and should have prompted respondent to investigate the possible causes of the weight loss. Dr. Carella charted Desiree D.'s growth rate as of March 4. By February, her rate of growth placed her in the 70th to 75th percentile, but by March 4, her growth rate placed

her in the 10th percentile. He explained a change in one major growth line (15 percentile) is significant, and here, Desiree D. crossed three major growth lines. Given this change and the mother's report the infant was feeding well, Dr. Carella felt something dramatic had occurred within the previous month, and that required respondent to perform a workup to determine the cause of the weight loss. According to Dr. Carella, respondent should have considered physical reasons such as diarrhea or a milk allergy or calculated calorie intake, examined the baby's physical appearance to determine if she was happy and smiling or appeared neglected, and environmental circumstances such as the mother neglecting the child or using drugs. He believed that given the birth history of the mother's drug use and failure to obtain prenatal care, respondent should have exhibited a higher index of suspicion and a more intensive evaluation. He pointed out one of the most common precursors of infant abuse is family drug abuse. He felt the weight loss could not be explained by oral thrush or a fever.

Dr. Carella reviewed the autopsy report and found a number of injuries that respondent might have discovered on March 4 had he examined Desiree D. more thoroughly, including the torn frenulum, a torn lip, eye hemorrhages, and bruises and fractures. A more thorough examination was required by the standard of care because of the weight loss and bruise. While respondent noted only one bruise on Desiree D.'s right cheek, his medical assistant observed multiple bruises and a photograph taken a few days after the visit but before the infant's death showed areas on Desiree D.'s left cheek and forehead that might have been pre-existing bruises, and should have further prompted respondent to investigate them.

Dr. Carella considered Dr. Hindman's findings, and believed some of the injuries should have been manifested on March 4. He testified any manipulation of Desiree D.'s long leg bones would have caused an extreme response for the baby, as would any maneuvering of the baby's arms.

Dr. Carella questioned respondent's inquiry into the explanation of the one bruise he did observe and chart. The parents' explanation was "falling toy." Dr. Carella was suspicious of the explanation in a four-month-old. He wondered how a toy heavy enough to cause the injury could have fallen on an infant lying in a crib. He conceded a mobile might fall on an infant, but that certainly would not be heavy enough to cause the bruise respondent observed. He pointed out it was rare for an abuser to truthfully explain an injury he or she inflicted. This explanation coming from a family abusing drugs Dr. Carella felt was not a reasonable one and it certainly would not have explained multiple bruises. Dr. Carella also noted the complaint of "hoarse voice." In the absence of a physical explanation such as croup or other etiology, the hoarseness might have been explained by screaming and irritability, and that should have told respondent there was something going on and should have prompted him to perform a more extensive examination and investigation.

In Dr. Carella's opinion, a competent pediatrician should have started an examination of Desiree D. with an extremely high level of suspicion because of the prenatal history, and from that point on, respondent should have been more thorough. There was evidence of a significant failure to thrive, must notably the significant weight loss but also the failure of the baby to respond to the thrush medication. Respondent's failure to interpret the signs of abuse

and neglect, in Dr. Carella's view, was incompetence and an extreme departure from the standard of care. Respondent, had he properly interpreted the information he had and investigated more thoroughly, would have found additional signs of abuse such as retinal hemorrhages and fractures and should have called the police.

15. Dr. Robert Morris was respondent's expert on the allegations relating to Desiree D. He is board certified in pediatrics since 1976 and in adolescent medicine, and did a fellowship at UCLA in pediatric gastroenterology. He served for three years as a lead physician at the Sylmar Juvenile Detention Facility and Chairman of the Child Abuse Committee, and since 1989 and has been a lead physician at the Central Juvenile Hall facility in Los Angeles. He was an assistant clinical professor of pediatrics and presently is an associate director of the Adolescent Medicine Program in the Department of Pediatrics at the UCLA Medical Center. He has served on a number of committees in the area of child abuse and neglect and conducted research related to gang activity. In the last two years, Dr. Morris has served as the statewide medical director for the state juvenile system.

In Dr. Morris' opinion, respondent's care and treatment of Desiree D. was not below the standard of care, and there was nothing in the baby's presentation on March 4 to warrant either a workup for abuse and/or a CPS report. He noted that after respondent ordered the mother's drug condition at birth be reported to CPS, a public health nurse would have been assigned to conduct an investigation, and a pediatrician could rely upon that investigation if the child was released to the mother.

Dr. Morris did not believe there was a connection between oral thrush and abuse, or the upper respiratory infections and abuse. However, he did feel the two conditions explained the baby's weight loss. He noted children do not exhibit a constant rate of growth, but rather children grow, and stop, and grow again at a jagged rate, and a child might stop if he or she is sick. He did not believe there was anything alarming about Desiree D.'s weight loss during February, and testified there could have been many causes for it, including the thrush and cold.

Dr. Morris testified in his opinion, no pediatrician would have picked up the fractures during the office visits in February and March. He pointed out babies heal rapidly. He did not believe a fracture could be diagnosed by swelling. He did not believe the one bruise respondent observed, coupled with the parents' explanation which seemed reasonable, was sufficient evidence for respondent to believe Desiree D. was abused.

16. For the investigation and enforcement of this matter, the Board incurred Attorney General's costs in the amount of $10,255.44, investigative services costs in the amount of $8,562.37, and record review costs in the amount of $2,775.00. The total is $21,592.81.

LEGAL CONCLUSIONS

1. In this proceeding, complainant bears the burden of establishing the charges by clear and convincing evidence to a reasonable certainty. *Ettinger* v. *Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853. This requires the evidence be "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and to be "so clear as to leave no substantial doubt." *In re Angelia P.* (1981) 28 Cal. 3d 908, 919; *In re David C.* (1984) 152 Cal.App.3d 1189, 1208. If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

2. Respondent has a duty to perform professional medical services for patients with that degree of learning and skill ordinarily possessed by reputable physicians practicing in the same or similar locality and under similar circumstances. A failure to fulfill any such duty is negligence. *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279. A lack of ordinary care defines negligent conduct. Gross negligence is defined as a want of even scant care or an extreme departure from the ordinary standard of care. *Van Meter v. Bent Construction Co.* (1946) 46 Cal. 2d 588. Repeated negligent acts by a physician consists of two or more negligent acts. *Zabetian* v. *Medical Board of California* (2000) 80 Cal.App.4th 462.

Incompetence is distinguished from negligence in that one may be competent or capable of performing a given duty, but negligent in performing that duty. A single act of negligence is not equivalent to incompetence. While a single negligent act under certain circumstances may reveal a general lack of ability to perform licensed duties, thereby supporting a finding of incompetence, a single honest failing in performing those duties, without more, does not constitute a finding of incompetence justifying sanctions. *See Kearl* v. *Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.

It is incumbent upon the trier of fact to determine the standard of professional learning, skill and care required of respondent only from the opinions of the physicians, including respondent, who have testified as expert witnesses as to such standard. The trier of fact must consider each such opinion and should weigh the qualifications of the witness and the reasons given for his or her opinion. The trier of fact must give each opinion the weight to which it deems it entitled.

3. The first amended accusation alleges respondent committed seven acts in his care and treatment of Desiree D. that demonstrate gross negligence, incompetence, and repeated negligent acts: Failing to recognize signs and symptoms of infant abuse; failing to obtain a thorough history on March 4; failing to perform a thorough physical examination on March 4; failing to notify Child Protective Services that the patient was a victim of abuse; failing to observe any evidence of any injury during the visits in February and March; failing to be aware the patient was at an increased risk of child abuse; and failing to reconcile his March 4, 1999 note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

A preliminary issue concerns Desiree D.'s condition on March 4, 1999, and specifically the number of bruises she exhibited. Respondent's medical assistant, Catherine

Carlson, wrote "bruised cheeks" in the section of the note where chief complaint is recorded, while respondent wrote "Bruised over rt. cheek area—fading." Carlson testified at the hearing, reluctantly, and had little recollection of the visit that occurred nearly five years ago. Police officers interviewed her on April 19, and at that time, she reported Desiree D. had bruises all over her cheeks, and when she asked the parents about them, they gave her three different explanations — a toy fell on her, she rolled over onto it, and she was sitting herself up and hit herself on the crib. She further told the officers she spoke to respondent about the baby after his examination was over and told him they had given her three excuses. She testified at the hearing she recalled more than one bruise, and that was consistent with her use of the word "bruises" in the chart note. She also recalled telling respondent the bruises were odd and the parents' reasons were different. Respondent testified he observed only one bruise and he accepted the parents' explanation of a toy falling on her.

Carlson's testimony is more persuasive. She noted it was her job in respondent's office to write down her observations, and when she saw something, she asked about it. She testified she had never seen a child so extensively injured by a toy, and thus recorded all the information she had. Furthermore, her description of multiple bruises is more consistent with the trauma experienced by the child than respondent's description of one fading bruise.

Thus, on March 4, 1999, Desiree D. was brought to respondent's office with evidence of recent injuries, and a history suggestive of abuse. Respondent's failure to note more than one bruise or question the parents in any detailed way are evidence of his insensitivity to the possibility the infant might have suffered abuse. According to Dr. Carella, there were a number of red flags, and respondent ignored them. Dr. Carella's testimony and report are reasonable and more persuasive than the testimony of Dr. Morris, and establish respondent committed gross negligence and demonstrated incompetence in his care and treatment of Desiree D.

Less weight is given to Dr. Morris' testimony. While his credentials are impressive, he testified in a manner suggesting he was working hard to defend respondent, and not presenting his opinions in an unbiased manner. He attacked Carlson unjustifiably for not recording what the parents said and not reporting that information to respondent before the visit. Further, Dr. Morris assumed Desiree D. presented with one bruise, and chose to believe respondent's version, not Carlson's. He did not review Dr. Hindman's report or the x-rays, and relied on other information reported to him by respondent's attorney. He had not reviewed the available information as comprehensively as Dr. Carella.

4. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(b), gross negligence in connection with his care and treatment of Desiree D., was established by reason of Findings 10 through 14 and Legal Conclusion 3.

5. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(d), incompetence in connection with his care and treatment of Desiree D., was established by reason of Findings 10 through 14 and Legal Conclusion 3.

6. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(c), repeated negligent acts in connection with his care and treatment of Desiree D., was established by reason of Findings 10.through 14 and Legal Conclusion 6.

7. The first amended accusation alleges respondent committed five acts in his care and treatment of Kristin S. that demonstrate incompetence and repeated negligent acts: He failed to diagnose and treat the RSV bronchiolitis; he failed to monitor the infant's respiratory rate and order pulse oxymetry; he said in his Medical Board interview that "rhonchi" is synonymous with "wheezing;" and he was unsure as to what medications he prescribed to the patient on February 3, 1999.

It was established respondent failed to monitor Kristin S.' respiratory rate, and that was negligent. Dr. Carella so testified, and Dr. Hamilton did not dispute that. He testified a respiratory rate in children is difficult to obtain and often, a doctor will look at other symptoms that might signal difficulty in breathing, such as panting, nose flaring, grunting, retractions between ribs, and so forth. Respondent, however, did not obtain a respiratory rate, did not indicate he would have had difficulty obtaining it, and did not indicate the presence or absence of other information that might help determine if Kristin S. were having difficulty breathing. The only information, therefore, is the absence of information in respondent's chart regarding the respiratory rate, and that is insufficient. It should be noted, however, the circumstantial evidence tended to show Kristin S. was not having difficulty breathing, and respondent believed she was not have difficulty breathing.

It was not established respondent's failure to order pulse oxymetry was below the standard of care. Dr. Carella, in his report, noted this was necessary to determine if hospitalization were required. He called it a standard admission criterion. Dr. Hamilton testified pulse oxymetry was not the standard of care in 1999, although it is now. Assuming it was the standard in 1999, respondent had not reached the point in his care of Kristin S. to have to decide if she should be hospitalized. He had ordered an RSV test and x-ray on February 3. Upon learning the RSV test was positive, his decision whether to hospitalize would require information about her oxygen level to help determine the severity of the disease. But when respondent last saw Kristin S. and ordered the RSV test and chest x-ray, that decision had yet to be addressed, and, tragically, he never had to make it. Dr. Carella, in his report, called pulse oxymetry in this case an extra precaution, while Dr. Hamilton called it nice but not required.

It is noteworthy that Dr. Carella surmised, based on the information in the chart and respondent's actions, that Kristin S. was not moderately compromised. There was no evidence that Kristin S. had any difficulty breathing, as reflected in the chart or the testimony, depositions, or actions of her parents, and that was later confirmed by the chest x-ray according to Dr. Carella. Respondent correctly felt Kristin S. on February 3 was sick enough to warrant the tests and a prescription for ventolin, but not so sick as to require hospitalization or additional tests. Under these circumstances, respondent's failure to order pulse oxymetry was not established by clear and convincing evidence to a reasonable certainty.

It was not established respondent failed to timely diagnose or treat Kristin S.' RSV. There was no evidence to support a conclusion respondent should have diagnosed it earlier than February 3, and he acted appropriately on February 3 by ordering the RSV test and chest x-ray. Respondent suspected it on February 3, but the appropriate time to make the diagnosis was after he received the test results, not before. In Dr. Carella's report, he noted the failure to adequately diagnose and treat moderate or severe RSV bronchiolitis would indicate a severe lack of knowledge, diagnostic ability, and clinical judgment if the child was in moderate distress, but he pointed out such distress was not demonstrated clinically or confirmed by the x-ray.

In his interview with the Medical Board and during his testimony, respondent equated "wheezing" and "rhonchi." Dr. Hamilton testified the two were not synonymous and explained the difference and observed he would quarrel with a doctor who wrote rhonchi and meant wheezing because a doctor should be precise, and if a doctor did not know the difference, that may be incompetence. Dr. Carella noted in his report respondent believed the two terms were synonymous, and did not comment about that. He testified that what respondent described as rhonchi might have been wheezing, but offered no opinion that respondent's belief the two are synonymous is negligent. Dr. Hamilton's passing observation about respondent's use of the two words does not establish respondent was negligent.

The final alleged act of negligence is that respondent was unsure what medications he prescribed for Kristin S. on February 3. Respondent's chart indicated his plan was for the infant to take ventolin, Tylenol and Benadryl. Kristin S.' mother testified respondent did not prescribe ventolin for Kristin S. Respondent did prescribe ventolin nebulyzer for Kristin S.' brother who respondent also saw on February 3. Respondent does not keep a copy of prescriptions in his chart. Pharmacy records indicate Albertson's Pharmacy filled prescriptions from respondent for acetaminophen and diphenhist for Kristin S. on February 3. Respondent had no independent recollection of this.

No expert testified on this matter. Dr. Carella wrote in his report, "Ventolin was prescribed and noted in the record however, whether or not this medication was even given is irrelevant since RSV bronchiolitis is unlikely to respond to this treatment modality versus a reactive airway disease or true asthmatic bronchitis induced by a viral trigger." In the absence of expert testimony that respondent's uncertainty about a prescription for ventolin was a departure from the standard of care, it must be concluded the allegation was not proven.

8. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(d), incompetence in connection with his care and treatment of Kristin S., was not established by reason of Findings 4 through 9 and Legal Conclusion 7. Complainant established respondent committed one negligent act. That is insufficient to prove a violation of section 2234(d). *Kearl* v. *Board of Medical Quality Assurance, supra.*

9. Cause for discipline of respondent's license for violation of Business and

Professions Code section 2234(c), repeated negligent acts in connection with his care and treatment of Kristin S., was established by reason of Findings 4 through 9 and Legal Conclusion 7. Complainant established that respondent's failure to monitor Kristin S.' respiratory rate was negligent. Taken together with the repeated negligent acts already established in Legal Conclusion 6 (as to patient Desiree), respondent's act of negligence with Kristen S. constitutes a repeated negligent act in violation of section 2234(c). *Zabetian v. Medical Board of California, supra.*

10. Cause for discipline of respondent's license for violation of Business and Professions Code section 2266, failure to maintain adequate records in connection with his care and treatment of Desiree D., was established by reason of Finding 10 and Legal Conclusion 3. Respondent noted only bruise on the child's right cheek. His assistant observed more than one bruise; respondent should also have observed and noted more than one bruise.

The first amended accusation alleges five other instances of respondent failing to maintain adequate records. It is alleged he failed to chart that Desiree D.'s caregivers gave conflicting versions of how the injury occurred, but they only gave respondent one version, a falling toy, and that is what he recorded. Whether he should have pressed them about this explanation is another matter. It is alleged respondent failed to note he would monitor Desiree D.'s situation in order to follow-up on Carlson's concerns, but that was not part of his examination. It is alleged respondent should have reconciled his observation of a bruise with Carlson's observation of "bruises." It is not a matter of reconciliation as one of observation, and as found above, respondent should have observed more than one bruise. In connection with Kristin S., it is alleged respondent charted he had prescribed ventolin when he was not sure whether or not he had prescribed the medication. However, there was no evidence the chart entry was false or inadequate. There was no evidence that no prescription was written, only that the pharmacy did not fill a prescription for ventolin on February 3. Kristin S.' parents may have had some ventolin from a previous prescription respondent gave either to Kristin S. or her brother, and chose to use that and not fill the prescription respondent gave them, or there may be some other explanation.

The first amended accusation contains four separate causes of action related to this note about ventolin. As noted in Legal Conclusion 7, Dr. Carella observed in his report that ventolin was irrelevant because RSV bronchiolitis was unlikely to respond to it. Thus, a prescription for ventolin, whether given or not, has no bearing on determining whether respondent's treatment of Kristin S. met or fell below the standard of care, so finding whether respondent did prescribe it or did not prescribe it adds nothing to this determination. It is a truly minor point.

11. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(e), dishonesty, was not established.

It is alleged in paragraph 12 A-I of the first amended accusation that respondent falsely stated at his Medical Board interview in connection with Desiree D. that his medical assistant had not told him that the caregivers had given him different versions of how the

bruising occurred, she had not told him anything about the patient until after the caregivers left his office, and he observed only one bruise. With respect to Kristin S., it is alleged, respondent created false medical records when he charted he prescribed ventolin, he falsely told the Medical Board he had prescribed ventolin, he falsely told the Medical Board and testified at the hearing that he did not know her parents were smokers, and he allowed his expert to falsely testify that respondent did not know the child's parents were smokers and that respondent had prescribed ventolin when the expert knew there was an issue as to whether ventolin had been prescribed.

Two Medical Board investigators and two consultants interviewed respondent on September 22, 1999. Regarding Desiree D., respondent told them that after the visit on March 4, Carlson asked him what he thought about the baby's face, and he responded the parents said something fell on the baby's head, and she said, "Okay." He told them he observed one bruise and got one explanation. The interviewers pointed him to the discrepancy between the explanation he recorded for the bruise and her report of "unknown reasons," and respondent said, "It happens. Because some parents don't want to talk to the nurse." He said he did not know what conversation Carlson had with the parents and she did not tell him she suspected child abuse. He said he did not think the bruise was significant.

It is not dishonest to fail to recall the details of a conversation, or recall them differently from someone else's recollection. Respondent was asked about a brief conversation he had with his medical assistant six months earlier. He gave one version, she gave another. There is no evidence or reason to believe respondent intentionally lied about what he observed or what Carlson told him. Disputes between witnesses describing the same event are common, and while Carlson's description of what she observed is more credible than respondent's, that does not, in the absence of other evidence, make his description dishonest. See, e.g., *Foster* v. *Board of Medical Quality Assurance* (1991) 227 Cal.App.3rd 1606, 1610 and cases cited therein.

Regarding Kristin S., during the interview, when he reviewed his chart note for February 3, respondent said he had prescribed ventolin, because that was what was in the note. There was no evidence that no prescription was written, only that the pharmacy did not fill a prescription for ventolin on February 3. This discrepancy hardly rises to the level of dishonesty. See Legal Conclusion 10; *Foster* v. *Board of Medical Quality Assurance, supra.*

Respondent's medical chart for Kristin S. contains a CHDP Assessment signed by respondent on August 21, 1998. One question asked is whether the patient is exposed to passive (second hand) smoke. The "No" box is checked. The hospital record of Kristin S.' birth contains an Obstetric Admitting Record and the "Yes" box relating to tobacco use is checked. The interviewers asked respondent about the questionnaire during his interview, but respondent said nothing about smoking. Contrary to complainant's claim, respondent was not asked on direct examination at the hearing if he knew Kristin S.' parents were smokers. On cross-examination, he said he knew that. Consequently, there is no evidentiary support for the allegations that respondent falsely told the Medical Board interviewers that he did not know Kristin S.' parents were smokers, and did not testify falsely at the hearing.

Respondent's expert, Dr. Hamilton, on direct examination was asked his opinion of respondent's care and treatment of Kristin S., and then was asked about respondent's records. He was asked about the assessment form and explained why the information was requested. He testified a doctor must be able to rely on the information contained on it and doctors do so. He testified he noticed the information on it regarding smoking and said doctors have no reason to believe families do not give information in good faith. He also commented on the explanation of Kristin S.' mother that she answered "No" to the question because she smoked only outside the house, not inside.

Dr. Hamilton did not testify that he did not know Kristin S.' parents were smokers and never used information about smoking when he expressed the reasons for his opinions. He was never asked if he knew independently of the records whether respondent knew the parents smoked. There is no evidence to suggest respondent "allowed" Dr. Hamilton to falsely testify about the parents smoking, nor is there any evidence to suggest respondent "allowed" Dr. Hamilton to falsely testify that respondent had prescribed ventolin.

12. Cause for discipline of respondent's license for violation of Business and Professions Code section 2261, false records, was not established for the reasons set forth in Legal Conclusions 10 and 11 relating to the ventolin prescription.

13. The Board incurred costs of investigation and enforcement of this matter in the amount of $21,592.81 (Factual Finding 16). Complainant prevailed on approximately half of the charges, primarily those related to respondent's care and treatment of Desiree D. The supporting declarations do not detail how much time was expended toward each of the cases. Accordingly, the only way to determine the reasonable costs is to reduce the total by half.

Cause to require respondent to reimburse the Board for its costs of investigation and prosecution of this matter pursuant to Business and Professions Code section 125.3 in the amount of $10,796.40 was established.

14. Respondent's major shortcoming as disclosed by the evidence was his failure to recognize and act upon a number of pieces of information that suggested Desiree D. might be the victim of child abuse. For that, he should be placed on probation and required to participate in a clinical training program such as P.A.C.E. The scope of his mistake is a rather limited one, however, and in light of respondent's background and training, does not require a lengthy period of probation. Respondent is board certified in both pediatrics and neonatology. He is the Chief of the Medical Staff at Victor Valley Community Hospital. A three-year period of probation would adequately protect the public.

ORDER

Physician's and surgeon's certificate number A 55917 issued to respondent Damodara Rajasekhar, M.D., is hereby revoked. However, the revocation is stayed and respondent is placed on probation for three (3) years on the following terms and conditions:

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review,

semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

2. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

6. Interview with the Division or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request

at various intervals and either with or without prior notice throughout the term of probation.

7. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

10. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $10,796.40 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Division for its costs.

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

14. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

This decision shall become effective on January 10, 2005.

IT IS SO ORDERED this 10th day of December, 2004.

RONALD L. MOY, M.D.
Chairperson, Panel B
Division of Medical Quality
Medical Board of California

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
DAMODARA RAJASEKHAR, M.D.	)	File No. 09-1999-96986
Physician & Surgeon's License # A-55917	)	
Respondent.	)	

ORDER GRANTING RECONSIDERATION

The Division of Medical Quality ("Division") issued a Decision in this matter dated April 14, 2004, with an effective date of May 14, 2004. A Request for Stay for the purpose of filing a Petition for Reconsideration was submitted by Mary Agnes Matyszeski, Deputy Attorney General, and a stay of execution of decision was granted to May 24, 2004. A Petition for Reconsideration was submitted by Mary Agnes Matyszeski, Deputy Attorney General, on May 21, 2004. A second Stay Order was granted until June 3, 2004, for the purpose of allowing time for the Agency to review and act on the filed Petition for Reconsideration.

Having reviewed the matter, the Division makes the following order:

> The Petition for Reconsideration is granted as to the legal issue presented in the Petition from the Office of the Attorney General. The effective date of the Panel's disciplinary decision was previously stayed until June 3, 2004. This stay shall remain in effect until the Board issues its Decision after Reconsideration.

Dated: June 3, 2004

for Brandon Ghizzoli, Chief of Enforcement
David T. Thornton
Interim Executive Director
Medical Board of California

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	File No: 09-1999-96986
DAMODARA RAJASEKHAR, M.D.	)	OAH No: L-2003040164
Physician's and Surgeon's Certificate # A-55917	)	
Respondent.	)	

ORDER GRANTING EXTENSION OF STAY

A Petition for Reconsideration having recently been filed, the stay of execution heretofore granted in this matter is hereby extended pursuant to Government Code Section 11521 (a), until June 3, 2004.

The stay is extended for the purpose of allowing the Board to consider the Petition for Reconsideration.

Dated: May 21, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Joan M. Jerzak
Chief of Enforcement

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
DAMODARA RAJASEKHAR, M.D.	)	**OAH No: L-2003040164**
Physician's and Surgeon's Certificate # A-55917	)	**MBC No: 09-1999-96986**
Respondent.	)	

ORDER GRANTING STAY

A Request for Stay for the Purpose of Filing Petition for Reconsideration was filed and a stay of execution of decision is hereby granted.

Execution is stayed until May 24, 2004.

This stay is granted solely for the purpose of allowing time to receive a Petition for Reconsideration.

DATED: May 13, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Joan M. Jerzak
Chief of Enforcement

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
DAMODARA RAJASEKHAR, M.D..	)	Case No: 09-1999-96986
Physician & Surgeon's Certificate No. A-55917	)	OAH No: L2002040150
Petitioner.	)	

ORDER DENYING PETITION FOR RECONSIDERATION AND REQUEST FOR STAY

The Petition for Reconsideration and Request for Stay, filed by Jeffrey G. Keane, Esq., on behalf of Damodara Rajasekhar, M.D., Respondent, for reconsideration of the decision in the above-entitled matter, having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on May 14, 2004.

IT IS SO ORDERED: May 11, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Joan M. Jerzak, Chief
Enforcement Program

REDACTED

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	Case No: 09-1999-96986
DAMODARA RAJASEKHAR, M.D.	)	
	)	OAH No: L2002040150
Physician and Surgeon's Certificate No: A-55917	)	
Respondent.	)	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby accepted and adopted by the Division of Medical Quality of the Medical Board of California, as its Decision in the above entitled matter.

This Decision shall become effective at 5:00 p.m. on May 14, 2004.

DATED April 14, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Steven B. Rubins, M.D.
Panel B
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAMODARA RAJASEKHAR, M.D. 18182 Outer Highway 18, #103 Apple Valley, CA 92307 Physician's and Surgeon's Certificate No. A 55917 Respondent.	Case No. 09-1999-96986 OAH No. L2002040150

PROPOSED DECISION

On June 23, 2003, in San Diego, California, and on June 24-26, 2003, and January 27, 2004, in Riverside, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Mary Agnes Matyszewski, Deputy Attorney General, represented complainant.

Jeffrey G. Keane, Attorney at Law, represented respondent.

The matter was submitted on January 27, 2004.

FACTUAL FINDINGS

1. On August 7, 2000, Ron Joseph, Executive Director, Medical Board of California (Board), filed Accusation No. 09-1999-96986 in his official capacity. Respondent filed a timely Notice of Defense. Complainant filed a First Amended Accusation on August 26, 2003, and an Amendment to the First Amended Accusation on October 25, 2003. The accusation centers upon respondent's care and treatment of two infants during 1998 and 1999.

2. On April 3, 1996, the Board issued Physician's and Surgeon's certificate No. A 55917 to respondent.

3. Respondent is 52 years of age. He attended the University of Madras, India, receiving a bachelor's degree in zoology in 1969 and his medical degree in 1976. He became a Diplomate in Child Health in 1978 after two more years of post-graduate work at the University of Madras. He taught pediatrics for a year and in 1979, he went to the New Medical Center in Abu Dhabi, United Arab Emirates, where he served as an attending physician in ambulatory pediatrics. He remained there for seven years, until he moved to the United Kingdom and began working in a series of national health hospitals in pediatrics and neonatology.

Respondent came to the United States in 1990 and did a one-year residency in pediatrics at the University of Connecticut. He became board certified in pediatrics in 1991 and began a fellowship in neonatal-perinatal medicine at the University of Massachusetts. He remained there for three years, until he moved to Kentucky, where he became chairman of the Department of Pediatrics and the Credentials Committee at the Mary Breckinridge Hospital in Hyden.

Respondent began a solo practice in pediatrics and neonatology in Apple Valley, California, in 1996. In 1997, he became board certified in neonatology, and in 1998, was recertified in pediatrics. About 15 percent of his practice is neonatology, and the rest is pediatrics. He is the only board certified neonatologist in the high desert. He is on staff at St. Mary's Hospital and Victor Valley Community Hospital, and is presently the Chief of Medical Staff at Victor Valley. He is serving as a board member and delegate of the California Medical Association-Organized Medical Staff Section and had attended AMA meetings as a CMA delegate.

Respondent's practice has not changed much over the years. He sees children for well child care, including physical examinations and shots, and sick visits. He has one medical assistant for the back office and another assistant who makes appointments and answers the phone. The medical assistant must prepare the chart, notes the complaints as related by the mother and records them, and takes vital signs and records them. Respondent has four examining rooms, and regularly uses three of them at a time.

4. Kristin S. was born on [redacted]t St. Mary's Regional Medical Center in Apple Valley, and respondent became her pediatrician. Her mother first brought her to respondent's office on June 30. At that time, her mother completed a New Patient Questionnaire, and in response to the question "Are there any smokers in the household?" her mother circled "No." That answer was false, because she and her husband did smoke. The St. Mary's Obstetric Admitting Record indicates Kristin S.' mother did smoke, but it was not established that respondent ever saw this record. At some point during the ensuing seven months, respondent learned Kristin S.' mother smoked.

The visit on June 30, 1998 was a two-week well baby check. Kristin S.' mother informed the medical assistant there were bumps on the baby and she had been coughing, sneezing, and had a loss of appetite for three days, and that information was recorded on the progress note routinely completed at the time of an office visit by respondent and his medical

assistant. The infant's mother told respondent she was breast feeding and the baby had been fussy for the last two days.

Respondent's well baby examinations include checking how the baby looks, moving its hands and legs, checking its color, examining its head, mouth, eyes, throat, ears, neck, listening to its heart and lungs, examining the abdomen, hips and ankles, checking its strength, and making sure if its testes have descended if the baby is a boy. Respondent's examination of Kristin S. revealed only congestion and an atopic rash. His diagnosis was upper respiratory infection (URI) because of the sneezing and coughing and atopic rash, and his plan was to treat the child with saline nasal drips. He gave her a routine hepatitis B injection and told her mother to return if the symptoms persisted.

Kristin S.' mother brought her baby back to respondent's office on July 27. This was a sick baby visit, and the mother reported to the medical assistant that Kristin S. had a runny nose, was coughing and was irritable for two days, bowel movements were not regular, and she was breast feeding all day. Her mother told respondent the baby had a cough and cold for one day, the baby was fussy but there had been no vomiting or diarrhea, bowel movements were irregular, breast milk was not adequate, and she herself had flu symptoms for the last few days. Respondent noted the baby had gained less than a pound since the last visit. He found everything within normal limits except for congestion, diagnosed URI, and recommended saline nasal drops and supplemental feeding.

The next visit took place on August 21. It was a new baby visit and there were no complaints. Respondent's examination revealed growth and development within normal limits, and gave her the scheduled injections.

The next visit on October 6 was a sick baby visit. Kristin S.' mother told respondent's medical assistant she had taken Kristin S. to the Emergency Room two weeks before for tonsillitis and was given amoxicillin, the baby still had some symptoms including coughing, the medications were not working, and there was an ear infection with drainage from her right ear. Kristin S.' mother repeated this information to respondent except for the ear drainage, and added the cough and congestion persisted, but there was no fever. The baby's temperature at the time of the visit was 99.3. Respondent found her throat was red (erythematous) and after examining her ears and chest, found they were clear. He diagnosed URI and prescribed Benadryl because there was a history of allergies in the family.

Kristin S.' mother brought the child back to respondent's office on December 10 for a sick visit because of a cold and coughing, and a low grade fever. The mother reported one of her siblings may have put a Q-tip in her ears. A temperature taken in the office was 99.2. Respondent found the child's throat was red, and her ears and chest were clear. He again diagnosed URI, but this time prescribed amoxicillin, along with Benadryl and Tylenol as needed.

Kristin S.' last visit to respondent's office occurred on February 3, 1999 and was a sick baby visit. It took place late in the afternoon. The complaints as related to the medical assistant included a temperature of 102, congestion, coughing and runny nose for three days.

The child's pulse and temperature taken in the office were normal. Kristin S.' mother told respondent the baby had been fussy for three days, had a fever for two days, had a cough and cold for three days, had vomited the day before but did not have diarrhea, and her appetite had decreased. Respondent's examination revealed her throat was red, her ears were fine, and there were scattered rhonchi. He diagnosed URI based on the runny nose and bronchiolitis based on the rhonchi. Respondent's office note indicates his plan was for the baby to take ventolin liquid, Tylenol and Benadryl. He also noted he would check for respiratory syncytial virus infection (RSV) and have a chest x-ray done. He sent Kristin S.' mother next door to St. Mary's lab to have the chest x-ray and RSV test performed. Respondent's chart note indicates he told the mother to call him if symptoms persisted.

Kristin S.' mother took her child to the lab for a chest x-ray and a nasopharyngeal RSV test. The radiologist read the chest x-ray on February 4 and reported it was normal. He reported "No lung consolidation is seen. . . The pulmonary vessels appear normal." The Board's expert noted the chest x-ray did not show any hyperinflation or flattened diaphragms which are diagnostic of moderate bronchiolitis.

The RSV test was positive and the results were reported to respondent at 7:45 p.m. on February 3. Respondent did not call Kristin S.' parents to advise them of the test results.

5. Kristin S.' parents took her home from the hospital and gave her Benadryl and the saline drops. She fell asleep in her mother's lap around 9:00 p.m. Her mother moved her onto the sofa, and let her sleep there through the night, while her parents went to bed. They did not check on her during the night. When her father checked her around 8:00 a.m., he found she was not breathing. Paramedics took her to St. Mary's Hospital where Dr. Dennis Wheeler of the Emergency Department saw her at 8:50 a.m. in full cardiopulmonary arrest. A chest x-ray taken in the emergency department revealed possible perihilar infiltrates typical of RSV bronchiolitis. The child never demonstrated any cardiac activity and was pronounced dead at 9:04 a.m. Dr. Wheeler's impression was SIDS associated with a non-lethal respiratory problem.

6. Dr. Frank Sheridan, a pathologist, performed an autopsy on Kristin S. on February 9. Regarding the respiratory tract, Dr. Sheridan found marked erythema of the epiglottis, and erythema of the mucosa of much of the trachea, no foreign material in the airway, and generalized congestion and equivocal consolidation particularly in the right lower lobe of the lungs. Microscopic examination of the respiratory tract revealed dense chronic inflammatory cell infiltrates in the submucosa of the larynx, bronchi, and bronchioles, extending focally into the pulmonary interstitium, and early focal alveolar consolidation. Dr. Sheridan's diagnosis was respiratory syncytial virus infection (RSV), based on positive clinical testing, epiglosottis, laryngitis, tracheitis, and bronchitis, and bronchiolitis with early penumonitis. He designated the cause of death as upper and lower respiratory tract infection, days, due to RSV, days.

7. RSV is a common respiratory virus that attacks children usually under the age of three. About 70 percent of children under the age of one have had it, and almost every child under the age of two has had it. It is seasonal, usually attacking in the winter and in

particular infecting young infants. It has a propensity to infect the lower bronchi. Its symptoms can range from an upper respiratory infection with mild symptoms like sniffles to severe pulmonary disease with respiratory distress, fast breathing, a fast heart rate, or audible wheezing in the lungs. It may lead to edema of the smaller air tubules in the respiratory tract and it can attack the heart causing arrhythmias. There is an increased risk for RSV if the child is premature, has congenital heart disease, or is exposed to second-hand smoke.

8. To support the allegations of incompetence and repeated negligent acts set forth in the first amended accusation, complainant called Dr. Joseph Carella. He attended Tufts University Medical School, graduating in 1965 and completed his internship and residency there. He is board certified in pediatrics. He served in the Navy for two years and then worked for a year in an emergency room. He opened his own private pediatric practice in 1972, and kept it until 1984, at which time he did a year of missionary work in Swaziland, Republic of South Africa. Since his return to the United States, he has been in what he called semi-private practice, with much of his work in various children's homes relating to abused children. He has reviewed three or four cases a year for the Board and is an assistant professor of pediatrics at UCI.

Dr. Carella reviewed respondent's chart and other relevant information, and concluded respondent's care and treatment of Kristin S. was negligent and incompetent. He criticized respondent for failing to obtain a respiratory rate to determine if there was lower respiratory tract involvement and for failing to note the color of the patient or whether she was in distress. He testified the standard of care required respondent to obtain a respiratory rate and respondent's failure to obtain it was a simple departure from the standard of care and demonstrated incompetence. He suspected Kristin S. was breathing fast and her breathing may have been compromised because she was not feeding well and was wheezing, and if that was the case, she should have been hospitalized.

Dr. Carella testified respondent's failure to obtain a pulse oximeter reading to measure the amount of oxygen in the child's blood was also a simple departure from the standard of practice. A lower oxygen level would show the lungs were compromised, and the lower the level, the more likely the child would be hospitalized. He felt if respondent believed there was sufficient reason to order an RSV test and chest x-ray, then a pulse oximeter test should also have been performed. Respondent had a pulse oximeter in his office. He suspected, however, Kristin S. was not that severely compromised because respondent did not admit her directly into the hospital but instead sent her to the hospital for testing.

Dr. Carella also believed respondent had a moral obligation and should have notified Kristin S.' parents that the RSV test was positive. He based this conclusion on a statement by Kristin S.' mother that respondent had told her he would call her and tell them the results of the test, and admit the child if she was positive for RSV. Dr. Carella believed respondent should then have obtained more information about the child, including her feeding.

Because respondent knew there was smoking in the home, according to Dr. Carella, respondent should have been more thorough and complete, and have a higher index of

suspicion. He felt respondent should also have been aware of other risk factors for RSV, including lower socioeconomic environments, less maternal education, school aged siblings, birth during RSV season, but he acknowledged that there were mitigating factors such as the child was older than six months, she was not premature, and she did not have chronic pulmonary disease to T-cell defects. Based on all these facts, he felt respondent should have taken extra precautions to include monitoring the respiration rate and pulse oxymetry and feeding patterns, and ensure there were not other complications from the RSV. In his opinion, these failures revealed a lack of clinical judgment and knowledge.

It was Dr. Carella's opinion that Kristin S. had a pan respiratory RSV infection which may have been the trigger for a SIDS event.

9. Dr. Robert Hamilton testified on behalf of respondent relating to the Kristin S. allegations. He is a general pediatrician with a private practice in Santa Monica. He is board certified in pediatrics. He attended the UCLA Medical School and did his internship and residency there. He is an assistant clinical professor of pediatrics at UCLA and an instructor in pediatrics at Western University School of Medicine in Pomona. He is the vice-chair of the Department of Pediatrics at St. Johns Health Center, a member of the Pediatric Committee and a clinical instructor of pediatrics at UCLA/Santa Monica Hospital, and a clinical instructor of pediatrics at Cedars-Sinai Hospital.

Dr. Hamilton reviewed respondent's records and other relevant information relating to his care and treatment of Kristin S., and concluded respondent did not violate the standard of care and was not incompetent. He agreed with Dr. Carella the cause of the child's death was probably SIDS.

Dr. Hamilton pointed out the record did not disclose Kristin S. was suffering from respiratory distress. The record disclosed a history of coughing and runny nose, but there were never any reports of difficulty in breathing. He pointed out it may be difficult to obtain a respiratory rate in children because they are frequently crying or fussing, but a doctor can easily see if a child is having difficulty breathing. He noted there was no evidence respondent ever observed the child panting or flaring her nose or grunting or exhibiting retractions of her ribs, for instance, or showing any other sign that she was having difficulty breathing. He felt such signs were more important than a number.

Dr. Hamilton testified the treatment for RSV depended on the level of illness, and noted younger children (under two months) were more affected by the virus. For a child to be hospitalized with RSV, there must be significant respiratory distress and an elevated temperature. In fact, a significant clinical picture even without a positive RSV test would probably require hospitalization, while a positive RSV test without an accompanying clinical picture does not require hospitalization. He also noted Kristin S. presented in February, which is a peak time for RSV. He felt that based on what respondent heard, he was justified in ordering a chest x-ray and giving her ventolin, a bronchodilator, but because she was afebrile and did not present as being in respiratory distress, but rather having mild to moderate respiratory problems, respondent's decision to order a chest x-ray was an indication of him being thorough and conservative, and his intuition proved correct.

In Dr. Hamilton's opinion, it was not below the standard of care for respondent to send Kristin S. for an RSV test and ask the parents to monitor her and call him, or call him for the results of the test. He testified respondent prescribed medications to make the child comfortable, she was afebrile and not in any significant distress when she went home, and therefore, he was justified in telling them to call him if anything occurred. Dr. Hamilton pointed out the normal chest x-ray meant there was no significant respiratory involvement such as a flattening of the diaphragm, and did not require any action that night because the child was not in any immediate danger. He felt that respondent speaking to the parents in the morning and reassessing the child either in his office or over the phone was appropriate.

Dr. Hamilton testified that at this time, a pulse oximeter reading in this situation is the standard of care, but was not the standard of care in 1999. He testified that not many doctors even had pulse oxymenters then, and it would have been very aggressive to send a patient to a hospital emergency room to have the oxygen level checked. He felt it would have been nice to have the oxygen level, but was not required in the absence of any evidence the child was not getting enough oxygen, and was not below the standard of care for respondent not to check Kristin S.' oxygen level even if he had a pulse oximeter in his office.

Dr. Hamilton read the depositions of Kristin S.' parents taken in connection with a civil case, and noted they did not show any panic or concern. He indicated they did not report any temperature elevation or difficulty in their child's breathing, they did not call respondent, and they did not take Kristin S. to an emergency room as they had done in the past. They went to bed, while leaving Kristin S. on a couch, and they made no effort to check her during the night. Based on this, he concluded Kristin S. appeared all right and was not acutely ill from the RSV such that it would have caused her death. In his experience, RSV proceeded slower. Indeed, the autopsy showed the RSV did not affect her airway and did not obstruct her breathing.

10. Desiree D. was born on [redacted] at St. Mary's Regional Medical Center, and respondent became her pediatrician. Her mother had received no prenatal care, and did not even know she was pregnant until shortly before she delivered. The mother's urine screen was positive for amphetamines as was the baby's. Based on that, respondent ordered social services to be notified.

Desiree D.'s first visit to respondent's office took place on November 17, 1998. It was a well baby visit and she was brought in by her parents. The child's weight was appropriate. Respondent found her growth and development were within normal limits and indicated she was doing well. Her two-month old visit on December 29 was likewise normal. The baby had gained two pounds since her previous visit. Respondent gave her routine shots on each of the first two visits.

The next visit, on February 1, 1999, occurred because Desiree D. was sick. Desiree D. had gained more than a pound since her last visit. Her mother reported white bumps on her tongue and she spit up a lot. Respondent noted the mother said Desiree D. had white lesions in the mouth for two days but was feeding all right. Respondent's examination

revealed oral thrush, and everything else was within normal limits. Thrush is a common fungal skin and mucous membrane infection. It does not have symptoms, interfere with feeding or cause weight loss, or cause fever or respiratory compromise, and is characterized by white plaques in the mouth, tongue, or gums, or a rash. Respondent prescribed Nystatin oral suspension and cream.

Desiree D.'s mother brought the baby back to respondent's office ten days later because she was coughing, congested, the thrush was still there, and she had lost weight. Comparing her weight on this visit to her previous visit shows a nine ounce weight loss. She did not have a fever and her mother reported none. Respondent found the oral thrush was extensive, that is, there was more than previously. He diagnosed oral thrush and URI. He changed the medication to gentian violet for thrush and also prescribed Dimetapp.

Desiree D.'s last visit to respondent's office occurred on March 4, 1999. She was brought in by her parents who told the medical assistant in part: "bruised cheeks, unknown reasons x 1 ½ wks—thrush still prominent, hoarse voice." She had lost two ounces since her last visit. Respondent recorded the parents told him she had had a fever for two days, the oral thrush was still there, there had been no vomiting or diarrhea, and "injury face due to falling toy 1 wk ago, feeding well." Respondent found the baby's throat was red, her ears and chest were clear, and he recorded "Bruised over rt. cheek area—fading." His diagnosis and plan were URI and oral thrush to be treated with amoxicillin, and Tylenol.

11. Desiree D. arrived at the St. Mary's Regional Medical Center emergency room at 4:40 p.m. on March 9, 1999 in full cardiac arrest. Paramedics performed CPR while in route to the hospital. According to the family's report, she was found lying down, cyanotic, and not breathing. Dr. Fletcher, the emergency room doctor who treated Desiree D., found she had no spontaneous respirations, blood pressure, or pulse. She noted bruising around the mouth and cheek area and under the chin and left ear. She found multiple areas of bruising about the face, frontal region, and left hip. Desiree D. was transported to Loma Linda University Pediatric ICU by life flight in critical condition.

Doctors at Loma Linda University determined on March 10 that Desiree D. was brain dead caused by a non-accidental trauma. Desiree D. was removed from a ventilator and she was pronounced dead at 12:01 p.m. The final diagnosis was fatal child abuse, with bilateral retinal hemorrhages, subdural hemorrhages, multiple rib fractures of varying ages, multiple long bone fractures including a metaphysical fracture, human bite marks, and multiple bruises of varying ages noted.

12. Dr. Sheridan performed an autopsy on Desiree D. on March 12, 1999. He determined the cause of death to be shaken baby syndrome with significant findings of chronic physical abuse. The diagnosis of shaken baby syndrome was supported by evidence of fresh subdural hematoma, fresh bilateral optic nerve sheath hemorrhage and retinal hemorrhage, diffuse axonal injury with cerebral edema, and early bronchopneumonia. The evidence of chronic physical abuse consisted of multiple cutaneous blunt force injuries of varying ages, bite marks on the left leg and left buttock, a tear of the frenulum of the upper lip which was healing, multiple left-sided rib fractures which were healing and acute,

multiple long bone metaphyseal fractures of the upper and lower extremities which were healing, and microscopic evidence of old subdural and optic nerve sheath hemorrhage. Dr. Sheridan commented the baby died as a result of a head injury due to violent shaking.

13. Respondent learned Desiree D. had been taken to St. Mary's and ordered a skeleton survey be performed. Dr. Bernard Hindman, a radiologist at Loma Linda University Medical Center, reviewed chest and abdominal radiographs taken on March 9 at St. Mary's and a bone survey performed at Loma Linda on March 10. He found multiple healed left rib fractures and a right posterior 10th rib fracture. The fracture line was consistent with early healing. There were healing fractures in the distal left femur, proximal right tibia, distal left tibia and fibula, and the distal radius bilaterally which was almost completely healed. He found soft tissue swelling adjacent to the healing fractures of the distal right radius and in the left ankle, suggesting a fracture two to three weeks old, perhaps less. The fractures in the distal left femur and posterior right 10th rib also appeared to be two to three weeks old, but he was less certain about the ages of those fractures than the ages of other fractures. He felt the fractures of the distal left radius and proximal right tibia were four to six weeks old. He could not determine the age of skull separation. He believed the fractures that were two to three weeks old should have been apparent symptomatically at the time of respondent's examination in March, and the older fractures should have been apparent symptomatically at the February visits.

14. The accusation alleges respondent was grossly negligent and incompetent and committed repeated negligent acts in his care and treatment of Desiree D. Dr. Carella served as complainant's expert and believed the evidence supported the charges.

Dr. Carella explained weight loss beginning with the February 11 visit was significant. By the March 4 visit, Desiree D. should have gained more than a pound and a half in light of the history related to him by her mother on March 4 that the infant was "feeding well." Instead, the infant lost nine ounces in the ten days between February 1 and February 11, and another two ounces during the ensuing three weeks. In addition, one of the mother's chief complaints on February 11 was weight loss. In Dr. Carella's, view, this was a red flag and should have prompted respondent to investigate the possible causes of the weight loss. Dr. Carella charted Desiree D.'s growth rate as of March 4. By February, her rate of growth placed her in the 70th to 75th percentile, but by March 4, her growth rate placed her in the 10th percentile. He explained a change in one major growth line (15 percentile) is significant, and here, Desiree D. crossed three major growth lines. Given this change and the mother's report the infant was feeding well, Dr. Carella felt something dramatic had occurred within the previous month, and that required respondent to perform a workup to determine the cause of the weight loss. According to Dr. Carella, respondent should have considered physical reasons such as diarrhea or a milk allergy or calculated calorie intake, examined the baby's physical appearance to determine if she was happy and smiling or appeared neglected, and environmental circumstances such as the mother neglecting the child or using drugs. He believed that given the birth history of the mother's drug use and failure to obtain prenatal care, respondent should have exhibited a higher index of suspicion and a more intensive evaluation. He pointed out one of the most common precursors of infant abuse is family drug abuse. He felt the weight loss could not be explained by oral thrush or a fever.

Dr. Carella reviewed the autopsy report and found a number of injuries that respondent might have discovered on March 4 had he examined Desiree D. more thoroughly, including the torn frenulum, a torn lip, eye hemorrhages, and bruises and fractures. A more thorough examination was required by the standard of care because of the weight loss and bruise. While respondent noted only one bruise on Desiree D.'s right cheek, his medical assistant observed multiple bruises and a photograph taken a few days after the visit but before the infant's death showed areas on Desiree D.'s left cheek and forehead that might have been pre-existing bruises, and should have further prompted respondent to investigate them.

Dr. Carella considered Dr. Hindman's findings, and believed some of the injuries should have been manifested on March 4. He testified any manipulation of Desiree D.'s long leg bones would have caused an extreme response for the baby, as would any maneuvering of the baby's arms.

Dr. Carella questioned respondent's inquiry into the explanation of the one bruise he did observe and chart. The parents' explanation was "falling toy." Dr. Carella was suspicious of the explanation in a four-month-old. He wondered how a toy heavy enough to cause the injury could have fallen on an infant lying in a crib. He conceded a mobile might fall on an infant, but that certainly would not be heavy enough to cause the bruise respondent observed. He pointed out it was rare for an abuser to truthfully explain an injury he or she inflicted. This explanation coming from a family abusing drugs Dr. Carella felt was not a reasonable one and it certainly would not have explained multiple bruises. Dr. Carella also noted the complaint of "hoarse voice." In the absence of a physical explanation such as croup or other etiology, the hoarseness might have been explained by screaming and irritability, and that should have told respondent there was something going on and should have prompted him to perform a more extensive examination and investigation.

In Dr. Carella's opinion, a competent pediatrician should have started an examination of Desiree D. with an extremely high level of suspicion because of the prenatal history, and from that point on, respondent should have been more thorough. There was evidence of a significant failure to thrive, must notably the significant weight loss but also the failure of the baby to respond to the thrush medication. Respondent's failure to interpret the signs of abuse and neglect, in Dr. Carella's view, was incompetence and an extreme departure from the standard of care. Respondent, had he properly interpreted the information he had and investigated more thoroughly, would have found additional signs of abuse such as retinal hemorrhages and fractures and should have called the police.

15. Dr. Robert Morris was respondent's expert on the allegations relating to Desiree D. He is board certified in pediatrics since 1976 and in adolescent medicine, and did a fellowship at UCLA in pediatric gastroenterology. He served for three years as a lead physician at the Sylmar Juvenile Detention Facility and Chairman of the Child Abuse Committee, and since 1989 and has been a lead physician at the Central Juvenile Hall facility in Los Angeles. He was an assistant clinical professor of pediatrics and presently is an associate director of the Adolescent Medicine Program in the Department of Pediatrics at the

UCLA Medical Center. He has served on a number of committees in the area of child abuse and neglect and conducted research related to gang activity. In the last two years, Dr. Morris has served as the statewide medical director for the state juvenile system.

In Dr. Morris' opinion, respondent's care and treatment of Desiree D. was not below the standard of care, and there was nothing in the baby's presentation on March 4 to warrant either a workup for abuse and/or a CPS report. He noted that after respondent ordered the mother's drug condition at birth be reported to CPS, a public health nurse would have been assigned to conduct an investigation, and a pediatrician could rely upon that investigation if the child was released to the mother.

Dr. Morris did not believe there was a connection between oral thrush and abuse, or the upper respiratory infections and abuse. However, he did feel the two conditions explained the baby's weight loss. He noted children do not exhibit a constant rate of growth, but rather children grow, and stop, and grow again at a jagged rate, and a child might stop if he or she is sick. He did not believe there was anything alarming about Desiree D.'s weight loss during February, and testified there could have been many causes for it, including the thrush and cold.

Dr. Morris testified in his opinion, no pediatrician would have picked up the fractures during the office visits in February and March. He pointed out babies heal rapidly. He did not believe a fracture could be diagnosed by swelling. He did not believe the one bruise respondent observed, coupled with the parents' explanation which seemed reasonable, was sufficient evidence for respondent to believe Desiree D. was abused.

16. For the investigation and enforcement of this matter, the Board incurred Attorney General's costs in the amount of $10,255.44, investigative services costs in the amount of $8,562.37, and record review costs in the amount of $2,775.00. The total is $21,592.81.

LEGAL CONCLUSIONS

1. In this proceeding, complainant bears the burden of establishing the charges by clear and convincing evidence to a reasonable certainty. *Ettinger* v. *Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853. This requires the evidence be "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and to be "so clear as to leave no substantial doubt." *In re Angelia P.* (1981) 28 Cal. 3d 908, 919; *In re David C.* (1984) 152 Cal.App.3d 1189, 1208. If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

2. Respondent has a duty to perform professional medical services for patients with that degree of learning and skill ordinarily possessed by reputable physicians practicing in the same or similar locality and under similar circumstances. A failure to fulfill any such duty is negligence. *Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279. A lack of ordinary

care defines negligent conduct. Gross negligence is defined as a want of even scant care or an extreme departure from the ordinary standard of care. *Van Meter v. Bent Construction Co.* (1946) 46 Cal. 2d 588. Repeated negligent acts by a physician consists of two or more negligent acts. *Zabetian* v. *Medical Board of California* (2000) 80 Cal.App.4th 462.

Incompetence is distinguished from negligence in that one may be competent or capable of performing a given duty, but negligent in performing that duty. A single act of negligence is not equivalent to incompetence. While a single negligent act under certain circumstances may reveal a general lack of ability to perform licensed duties, thereby supporting a finding of incompetence, a single honest failing in performing those duties, without more, does not constitute a finding of incompetence justifying sanctions. *See Kearl* v. *Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.

It is incumbent upon the trier of fact to determine the standard of professional learning, skill and care required of respondent only from the opinions of the physicians, including respondent, who have testified as expert witnesses as to such standard. The trier of fact must consider each such opinion and should weigh the qualifications of the witness and the reasons given for his or her opinion. The trier of fact must give each opinion the weight to which it deems it entitled.

3. The first amended accusation alleges respondent committed seven acts in his care and treatment of Desiree D. that demonstrate gross negligence, incompetence, and repeated negligent acts: Failing to recognize signs and symptoms of infant abuse; failing to obtain a thorough history on March 4; failing to perform a thorough physical examination on March 4; failing to notify Child Protective Services that the patient was a victim of abuse; failing to observe any evidence of any injury during the visits in February and March; failing to be aware the patient was at an increased risk of child abuse; and failing to reconcile his March 4, 1999 note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

A preliminary issue concerns Desiree D.'s condition on March 4, 1999, and specifically the number of bruises she exhibited. Respondent's medical assistant, Catherine Carlson, wrote "bruised cheeks" in the section of the note where chief complaint is recorded, while respondent wrote "Bruised over rt. cheek area—fading." Carlson testified at the hearing, reluctantly, and had little recollection of the visit that occurred nearly five years ago. Police officers interviewed her on April 19, and at that time, she reported Desiree D. had bruises all over her cheeks, and when she asked the parents about them, they gave her three different explanations — a toy fell on her, she rolled over onto it, and she was sitting herself up and hit herself on the crib. She further told the officers she spoke to respondent about the baby after his examination was over and told him they had given her three excuses. She testified at the hearing she recalled more than one bruise, and that was consistent with her use of the word "bruises" in the chart note. She also recalled telling respondent the bruises were odd and the parents' reasons were different. Respondent testified he observed only one bruise and he accepted the parents' explanation of a toy falling on her.

Carlson's testimony is more persuasive. She noted it was her job in respondent's office to write down her observations, and when she saw something, she asked about it. She

testified she had never seen a child so extensively injured by a toy, and thus recorded all the information she had. Furthermore, her description of multiple bruises is more consistent with the trauma experienced by the child than respondent's description of one fading bruise.

Thus, on March 4, 1999, Desiree D. was brought to respondent's office with evidence of recent injuries, and a history suggestive of abuse. Respondent's failure to note more than one bruise or question the parents in any detailed way are evidence of his insensitivity to the possibility the infant might have suffered abuse. According to Dr. Carella, there were a number of red flags, and respondent ignored them. Dr. Carella's testimony and report are reasonable and more persuasive than the testimony of Dr. Morris, and establish respondent committed gross negligence and demonstrated incompetence in his care and treatment of Desiree D.

Less weight is given to Dr. Morris' testimony. While his credentials are impressive, he testified in a manner suggesting he was working hard to defend respondent, and not presenting his opinions in an unbiased manner. He attacked Carlson unjustifiably for not recording what the parents said and not reporting that information to respondent before the visit. Further, Dr. Morris assumed Desiree D. presented with one bruise, and chose to believe respondent's version, not Carlson's. He did not review Dr. Hindman's report or the x-rays, and relied on other information reported to him by respondent's attorney. He had not reviewed the available information as comprehensively as Dr. Carella.

4. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(b), gross negligence in connection with his care and treatment of Desiree D., was established by reason of Findings 10 through 14 and Legal Conclusion 3.

5. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(d), incompetence in connection with his care and treatment of Desiree D., was established by reason of Findings 10 through 14 and Legal Conclusion 3.

6. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(c), repeated negligent acts in connection with his care and treatment of Desiree D., was established by reason of Findings 10.through 14 and Legal Conclusion 6.

7. The first amended accusation alleges respondent committed five acts in his care and treatment of Kristin S. that demonstrate incompetence and repeated negligent acts: He failed to diagnose and treat the RSV bronchiolitis; he failed to monitor the infant's respiratory rate and order pulse oxymetry; he said in his Medical Board interview that "rhonchi" is synonymous with "wheezing;" and he was unsure as to what medications he prescribed to the patient on February 3, 1999.

It was established respondent failed to monitor Kristin S.' respiratory rate, and that was negligent. Dr. Carella so testified, and Dr. Hamilton did not dispute that. He testified a respiratory rate in children is difficult to obtain and often, a doctor will look at other symptoms that might signal difficulty in breathing, such as panting, nose flaring, grunting,

retractions between ribs, and so forth. Respondent, however, did not obtain a respiratory rate, did not indicate he would have had difficulty obtaining it, and did not indicate the presence or absence of other information that might help determine if Kristin S. were having difficulty breathing. The only information, therefore, is the absence of information in respondent's chart regarding the respiratory rate, and that is insufficient. It should be noted, however, the circumstantial evidence tended to show Kristin S. was not having difficulty breathing, and respondent believed she was not have difficulty breathing.

It was not established respondent's failure to order pulse oxymetry was below the standard of care. Dr. Carella, in his report, noted this was necessary to determine if hospitalization were required. He called it a standard admission criterion. Dr. Hamilton testified pulse oxymetry was not the standard of care in 1999, although it is now. Assuming it was the standard in 1999, respondent had not reached the point in his care of Kristin S. to have to decide if she should be hospitalized. He had ordered an RSV test and x-ray on February 3. Upon learning the RSV test was positive, his decision whether to hospitalize would require information about her oxygen level to help determine the severity of the disease. But when respondent last saw Kristin S. and ordered the RSV test and chest x-ray, that decision had yet to be addressed, and, tragically, he never had to make it. Dr. Carella, in his report, called pulse oxymetry in this case an extra precaution, while Dr. Hamilton called it nice but not required.

It is noteworthy that Dr. Carella surmised, based on the information in the chart and respondent's actions, that Kristin S. was not moderately compromised. There was no evidence that Kristin S. had any difficulty breathing, as reflected in the chart or the testimony, depositions, or actions of her parents, and that was later confirmed by the chest x-ray according to Dr. Carella. Respondent correctly felt Kristin S. on February 3 was sick enough to warrant the tests and a prescription for ventolin, but not so sick as to require hospitalization or additional tests. Under these circumstances, respondent's failure to order pulse oxymetry was not established by clear and convincing evidence to a reasonable certainty.

It was not established respondent failed to timely diagnose or treat Kristin S.' RSV. There was no evidence to support a conclusion respondent should have diagnosed it earlier than February 3, and he acted appropriately on February 3 by ordering the RSV test and chest x-ray. Respondent suspected it on February 3, but the appropriate time to make the diagnosis was after he received the test results, not before. In Dr. Carella's report, he noted the failure to adequately diagnose and treat moderate or severe RSV bronchiolitis would indicate a severe lack of knowledge, diagnostic ability, and clinical judgment if the child was in moderate distress, but he pointed out such distress was not demonstrated clinically or confirmed by the x-ray.

In his interview with the Medical Board and during his testimony, respondent equated "wheezing" and "rhonchi." Dr. Hamilton testified the two were not synonymous and explained the difference and observed he would quarrel with a doctor who wrote rhonchi and meant wheezing because a doctor should be precise, and if a doctor did not know the difference, that may be incompetence. Dr. Carella noted in his report respondent believed

the two terms were synonymous, and did not comment about that. He testified that what respondent described as rhonchi might have been wheezing, but offered no opinion that respondent's belief the two are synonymous is negligent. Dr. Hamilton's passing observation about respondent's use of the two words does not establish respondent was negligent.

The final alleged act of negligence is that respondent was unsure what medications he prescribed for Kristin S. on February 3. Respondent's chart indicated his plan was for the infant to take ventolin, Tylenol and Benadryl. Kristin S.' mother testified respondent did not prescribe ventolin for Kristin S. Respondent did prescribe ventolin nebulyzer for Kristin S.' brother who respondent also saw on February 3. Respondent does not keep a copy of prescriptions in his chart. Pharmacy records indicate Albertson's Pharmacy filled prescriptions from respondent for acetaminophen and diphenhist for Kristin S. on February 3. Respondent had no independent recollection of this.

No expert testified on this matter. Dr. Carella wrote in his report, "Ventolin was prescribed and noted in the record however, whether or not this medication was even given is irrelevant since RSV bronchiolitis is unlikely to respond to this treatment modality versus a reactive airway disease or true asthmatic bronchitis induced by a viral trigger." In the absence of expert testimony that respondent's uncertainty about a prescription for ventolin was a departure from the standard of care, it must be concluded the allegation was not proven.

8. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(d), incompetence in connection with his care and treatment of Kristin S., was not established by reason of Findings 4 through 9 and Legal Conclusion 7. Complainant established respondent committed one negligent act. That is insufficient to prove a violation of section 2234(d). *Kearl* v. *Board of Medical Quality Assurance, supra.*

9. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(c), repeated negligent acts in connection with his care and treatment of Kristin S., was not established by reason of Findings 4 through 9 and Legal Conclusion 7. Complainant established respondent committed one negligent act. That is insufficient to prove a violation of section 2234(c). *Zabetian* v. *Medical Board of California, supra.*

10. Cause for discipline of respondent's license for violation of Business and Professions Code section 2266, failure to maintain adequate records in connection with his care and treatment of Desiree D., was established by reason of Finding 10 and Legal Conclusion 3. Respondent noted only bruise on the child's right cheek. His assistant observed more than one bruise; respondent should also have observed and noted more than one bruise.

The first amended accusation alleges five other instances of respondent failing to maintain adequate records. It is alleged he failed to chart that Desiree D.'s caregivers gave conflicting versions of how the injury occurred, but they only gave respondent one version, a

falling toy, and that is what he recorded. Whether he should have pressed them about this explanation is another matter. It is alleged respondent failed to note he would monitor Desiree D.'s situation in order to follow-up on Carlson's concerns, but that was not part of his examination. It is alleged respondent should have reconciled his observation of a bruise with Carlson's observation of "bruises." It is not a matter of reconciliation as one of observation, and as found above, respondent should have observed more than one bruise. In connection with Kristin S., it is alleged respondent charted he had prescribed ventolin when he was not sure whether or not he had prescribed the medication. However, there was no evidence the chart entry was false or inadequate. There was no evidence that no prescription was written, only that the pharmacy did not fill a prescription for ventolin on February 3. Kristin S.' parents may have had some ventolin from a previous prescription respondent gave either to Kristin S. or her brother, and chose to use that and not fill the prescription respondent gave them, or there may be some other explanation.

The first amended accusation contains four separate causes of action related to this note about ventolin. As noted in Legal Conclusion 7, Dr. Carella observed in his report that ventolin was irrelevant because RSV bronchiolitis was unlikely to respond to it. Thus, a prescription for ventolin, whether given or not, has no bearing on determining whether respondent's treatment of Kristin S. met or fell below the standard of care, so finding whether respondent did prescribe it or did not prescribe it adds nothing to this determination. It is a truly minor point.

11. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234(e), dishonesty, was not established.

It is alleged in paragraph 12 A-I of the first amended accusation that respondent falsely stated at his Medical Board interview in connection with Desiree D. that his medical assistant had not told him that the caregivers had given him different versions of how the bruising occurred, she had not told him anything about the patient until after the caregivers left his office, and he observed only one bruise. With respect to Kristin S., it is alleged, respondent created false medical records when he charted he prescribed ventolin, he falsely told the Medical Board he had prescribed ventolin, he falsely told the Medical Board and testified at the hearing that he did not know her parents were smokers, and he allowed his expert to falsely testify that respondent did not know the child's parents were smokers and that respondent had prescribed ventolin when the expert knew there was an issue as to whether ventolin had been prescribed.

Two Medical Board investigators and two consultants interviewed respondent on September 22, 1999. Regarding Desiree D., respondent told them that after the visit on March 4, Carlson asked him what he thought about the baby's face, and he responded the parents said something fell on the baby's head, and she said, "Okay." He told them he observed one bruise and got one explanation. The interviewers pointed him to the discrepancy between the explanation he recorded for the bruise and her report of "unknown reasons," and respondent said, "It happens. Because some parents don't want to talk to the nurse." He said he did not know what conversation Carlson had with the parents and she did not tell him she suspected child abuse. He said he did not think the bruise was significant.

It is not dishonest to fail to recall the details of a conversation, or recall them differently from someone else's recollection. Respondent was asked about a brief conversation he had with his medical assistant six months earlier. He gave one version, she gave another. There is no evidence or reason to believe respondent intentionally lied about what he observed or what Carlson told him. Disputes between witnesses describing the same event are common, and while Carlson's description of what she observed is more credible than respondent's, that does not, in the absence of other evidence, make his description dishonest. See, e.g., *Foster* v. *Board of Medical Quality Assurance* (1991) 227 Cal.App.3rd 1606, 1610 and cases cited therein.

Regarding Kristin S., during the interview, when he reviewed his chart note for February 3, respondent said he had prescribed ventolin, because that was what was in the note. There was no evidence that no prescription was written, only that the pharmacy did not fill a prescription for ventolin on February 3. This discrepancy hardly rises to the level of dishonesty. See Legal Conclusion 10; *Foster* v. *Board of Medical Quality Assurance, supra.*

Respondent's medical chart for Kristin S. contains a CHDP Assessment signed by respondent on August 21, 1998. One question asked is whether the patient is exposed to passive (second hand) smoke. The "No" box is checked. The hospital record of Kristin S.' birth contains an Obstetric Admitting Record and the "Yes" box relating to tobacco use is checked. The interviewers asked respondent about the questionnaire during his interview, but respondent said nothing about smoking. Contrary to complainant's claim, respondent was not asked on direct examination at the hearing if he knew Kristin S.' parents were smokers. On cross-examination, he said he knew that. Consequently, there is no evidentiary support for the allegations that respondent falsely told the Medical Board interviewers that he did not know Kristin S.' parents were smokers, and did not testify falsely at the hearing.

Respondent's expert, Dr. Hamilton, on direct examination was asked his opinion of respondent's care and treatment of Kristin S., and then was asked about respondent's records. He was asked about the assessment form and explained why the information was requested. He testified a doctor must be able to rely on the information contained on it and doctors do so. He testified he noticed the information on it regarding smoking and said doctors have no reason to believe families do not give information in good faith. He also commented on the explanation of Kristin S.' mother that she answered "No" to the question because she smoked only outside the house, not inside.

Dr. Hamilton did not testify that he did not know Kristin S.' parents were smokers and never used information about smoking when he expressed the reasons for his opinions. He was never asked if he knew independently of the records whether respondent knew the parents smoked. There is no evidence to suggest respondent "allowed" Dr. Hamilton to falsely testify about the parents smoking, nor is there any evidence to suggest respondent "allowed" Dr. Hamilton to falsely testify that respondent had prescribed ventolin.

12. Cause for discipline of respondent's license for violation of Business and Professions Code section 2261, false records, was not established for the reasons set forth in Legal Conclusions 10 and 11 relating to the ventolin prescription.

13. The Board incurred costs of investigation and enforcement of this matter in the amount of $21,592.81 (Factual Finding 16). Complainant prevailed on approximately half of the charges, those related to respondent's care and treatment of Desiree D., and did not prevail on the charges related to his care and treatment of Kristin S. The supporting declarations do not detail how much time was expended toward each of the cases. Accordingly, the only way to determine the reasonable costs is to reduce the total by half.

Cause to require respondent to reimburse the Board for its costs of investigation and prosecution of this matter pursuant to Business and Professions Code section 125.3 in the amount of $10,796.40 was established.

14. Respondent's major shortcoming as disclosed by the evidence was his failure to recognize and act upon a number of pieces of information that suggested Desiree D. might be the victim of child abuse. For that, he should be placed on probation and required to participate in a clinical training program such as P.A.C.E. The scope of his mistake is a rather limited one, however, and in light of respondent's background and training, does not require a lengthy period of probation. Respondent is board certified in both pediatrics and neonatology. He is the Chief of the Medical Staff at Victor Valley Community Hospital. A three-year period of probation would adequately protect the public

ORDER

Physician's and surgeon's certificate number A 55917 issued to respondent Damodara Rajasekhar, M.D., is hereby revoked. However, the revocation is stayed and respondent is placed on probation for three (3) years on the following terms and conditions:

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its

designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

2. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

6. Interview with the Division or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

7. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the

probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

10. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke

Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $10,796.40 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Division for its costs.

12. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

14. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

DATED: 2/18/04

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 25, 2003
BY Allen Bryson ANALYST

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAMODARA RAJASEKHAR, M.D.** 18182 Outer Highway 18, #103 Apple Valley, 92307 CA Physician's and Surgeon's Certificate No. A 55917 Respondent.	Case No. 09-2002-134128 OAH No. L-2003-040164 **AMENDMENT TO FIRST AMENDED ACCUSATION**

Complainant makes the following amendment to the First Amended Accusation:

1. Page 13, Add as Paragraph I: "Respondent allowed his expert to falsely testify respondent had prescribed Ventolin to Kristin S., when, in fact, both respondent and his expert knew there was an issue as to whether or not Ventolin had been prescribed.

DATED: October 25, 2003

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

REDACTED

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 26, 2003
BY [signature] ANALYST

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

DAMODARA RAJASEKHAR, M.D.
18182 Outer Highway 18, #103
Apple Valley, 92307 CA

Physician's and Surgeon's
Certificate No. A 55917

Respondent

Case No. 09-1999-96986

FIRST AMENDED ACCUSATION

Complainant, Ron Joseph, as cause for disciplinary action alleges:

PARTIES

1. Complainant brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about April 3, 1996, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 55917 to Damodara Rajasekhar, M.D. ("Respondent"). The physician's and surgeon's certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2003, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), under the authority of the following sections of the Business and Professions Code ("Code").

A. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have the license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

". . . .

(b) Gross negligence

(c) Repeated negligent acts.

(d) Incompetence.

(e) Dishonesty

". . . ."

C. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

D. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

E. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. Section 14124.12 of the Welfare and Institutions Code provides, in pertinent part, that: "Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

5. Respondent, Damodara Rajasekhar, M.D., is subject to disciplinary action on account of the following:

Patient Desiree D.

A. On or about [redacted], this female patient was born by caesarean section delivery. The patient was born to a substance abusive mother who did not have the benefit of pre-natal care because she was unaware of the pregnancy until shortly before the day of delivery. The patient tested positive for amphetamine at birth. On or about November 17 and December 29, 1998, the patient made routine "well baby" visits to respondent's offices. The patient's weight as noted by respondent was 8 pounds 12 ounces and 10 pounds 12 ounces, respectively.

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B. On or about February 1, 1999, at age three-months-old, the patient made a "sick baby" visit with complaints of "white bumps on tongue," "spits up a lot" and "thrush." Respondent noted the patient was "feeding O.K." His impression was thrush for which he prescribed Nystatin. The patient weighed 12 pounds 1ounce.

C. On or about February 11, 1999, the patient made another visit with complaints of coughing, congestion, phlegm, "thrush still there" and weight loss. The patient's weight was 11 pounds 8ounces. Respondent's impression was "worsening thrush." He prescribed Gentian Violet.

D. On or about March 4, 1999, the patient made another visit with complaints of "bruised cheeks, unknown reasons for 1½ weeks" and hoarse voice, among other things. The patient weighed 11 pounds 6 ounces. (The patient's weight should have been approximately 13 pounds 2 ounces). Before respondent's examination of the patient, his medical assistant informed him that the patient had multiple bruises on the cheeks and forehead and that the mother and her boyfriend had given conflicting causes for the bruises. Respondent took a history and performed a physical examination. He noted the patient had "fever two days, oral thrush," was "feeding well," had "throat erythematous" and that the "bruises on the right cheek area were fading." Respondent's impression included "URI" (Upper Respiratory Infection) for which he prescribed Amoxil.

E. On the patient's visit on or about March 4, 1999, respondent failed to obtain a thorough history regarding the causes of the bruises on the patient's cheeks and forehead; failed to perform a complete physical examination in that he failed to examine the patient's joints, buttocks and genitalia; failed to conduct an investigation into the cause of the patient's loss of weight in spite of the reports that the patient was "feeding well;" and, failed to note that the patient had bruises on the forehead as well as on both cheeks.

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F. On March 9, 1999, the patient was found in full cardiac arrest in her crib. She was transported to St. Mary's Hospital emergency room and then later to Loma Linda University Medical Center where she was declared brain dead from shaken baby syndrome. At both hospitals, the patient was noted to have multiple bilateral rib fractures at various stages of healing. Bruises were also found around her mouth, cheeks, left ear, forehead and left hip area. The autopsy report also found bruises on the forehead, cheeks, left chest, left knee and left buttocks, and a torn upper lip frenulum.

G. A correlation between the fractures and the office visits indicates that at least at the February and March visits, respondent should have been able to observe some evidence of the injuries to the baby which were present on March 9, 1999.

6. Respondent, Damodara Rajasekhar, is subject to disciplinary action for unprofessional conduct in that he has committed acts or omissions constituting gross negligence in violation of Code section 2234(b) in that:

A. Respondent failed to recognize signs and symptoms of infant abuse in a four-month-old patient who presented with multiple unexplained bruises on the forehead and cheeks, hoarse voice and weight loss despite reports the patient was "feeding well."

B. At the visit on or about March 4, 1999, respondent failed to obtain a thorough history on a four-month-old patient who presented with bruises on the cheeks and forehead, hoarse voice and weight loss despite reports the patient was "feeding well."

C. On the visit on or about March 4, 1999, respondent failed to perform a thorough physical examination on a four-month-old patient with complaints of bruises, hoarse voice and loss of weight in spite of reports the patient was "feeding well."

D. Respondent failed to notify Child Protective Services that the patient was the victim of abuse.

E. Respondent failed to observe any evidence of injury at the visits in February and March, although the autopsy and x-rays demonstrated that many of those injuries would have been present when respondent was examining the baby.

F. Respondent failed to be aware that the patient was at an increased risk of child abuse because she had been born methamphetamine-positive, her mother had been drug-positive at the delivery, there had been no prenatal care and the baby was living with her mother and non-maternal boyfriend.

G. Respondent failed to reconcile his March 9, 1999, note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

7. Respondent, Damodara Rajasekhar, M.D., is further subject to disciplinary action for unprofessional conduct in that he committed acts or omissions constituting incompetence in violation of section 2234(d) of the Code in that:

Patient Desiree D.

A. Respondent failed to recognize signs and symptoms of infant abuse in a four-month-old patient who presented with multiple unexplained bruises, hoarse voice and weight loss in spite of reports the patient was "feeding well."

B. On the visit on or about March 4, 1999, respondent failed to obtain a thorough history on a four-month-old patient who presented with bruises on the cheeks and forehead, hoarse voice and weight loss despite reports the patient was "feeding well."

C. On the visit on or about March 4, 1999, respondent failed to perform a thorough physical examination on a four-month-old patient with complaints of bruises, hoarse voice and loss of weight in spite of reports the patient was "feeding well."

D. Respondent failed to notify Child Protective Services that the patient was the victim of abuse.

E. Respondent failed to observe any evidence of the fractures or the injuries to the baby at the visits in February and March, although the autopsy and x-rays demonstrated that many of those injuries would have been present when respondent was examining the baby.

F. Respondent failed to be aware that the patient was at an increased risk of child abuse because she had been born methamphetamine-positive, her mother had been drug-positive at the delivery, there had been no prenatal care and the baby was living with her mother and non-maternal boyfriend.

G. Respondent failed to reconcile his March 9, 1999, note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

8. Respondent, Damodara Rajasekhar, M.D., is subject to disciplinary action on account of the following:

Patient Kristin S.

A. On or about June 30, 1998, this two-week-old patient presented at respondent's offices with complaints of coughing, sneezing and rash. The patient's parents were cigarette smokers. Respondent's diagnosis on this date was viral URI (Upper Respiratory Infection) and atopic rash. He prescribed saline nose drops.

B. On July 27, 1998, the patient made another visit with complaints of cough and congestion. Respondent's diagnosis was again URI. He again recommended saline drops.

C. On October 6, 1998, the patient made another visit with complaints of persistent cough and congestion. Two weeks before this visit, the patient had presented at the Desert Hospital Emergency Room and had been diagnosed with tonsilitis and treated with Amoxil. Respondent examined the patient; however, respondent failed to obtain a respiratory rate and failed to make a specific auscultory finding. Respondent's impression was URI. He prescribed Benadryl.

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D. On or about December 10, 1998, the patient, now five-months-old, made another visit with complaints of cough, low fever and "pulling on her ears." Respondent obtained a history and noted the patient had persistent cough and congestion. However, respondent failed to inquire into the patient's exposure to second-hand smoke at home. Respondent's diagnosis was "erythematous throat" for which he prescribed Benadryl and Tylenol.

E. On or about February 3, 1999, the patient made a visit with complaints of cough and fussiness for three days, 102-degree temperature, fever and vomiting. Vital signs were obtained but respondent failed to obtain or document the patient's respiratory rate. Respondent's objective findings included "erythematous throat" and "scattered ronchi." His impression was URI (Upper Respiratory Infection) and Bronchiolitis. He charted that he prescribed "Ventolin ½ tsp tid 5 days, Tylenol PRN and Benadryl 2 ml tid 5 days, " although he admitted for the firs time at the hearing that he is unsure as to whether or not he prescribed Ventolin to the patient.

F. Kristin S.'s parents contend that Ventolin was never prescribed to their daughter. The pharmacy records, which were subpoenaed by respondent, demonstrated that a prescription for Ventolin was never dispensed by the pharmacy, although prescriptions for Tylenol and Benadryl were dispensed.

G. Respondent did order a chest x-ray and a Respiratory Syncytial Virus (RSV) test at the February 3, 1999 visit, but failed to order a pulse oxymetry. At about 7:45 p.m., respondent was informed the RSV test was positive. Respondent failed to communicate this information to the patient's parents. Later in the evening on February 3, 1999, the patient fell asleep on the living room couch and was left there all night. At about 8:21 a.m., on February 4, 1999, the patient was found apneic and unresponsive. She was transported to the emergency room where she was pronounced dead at about 9:04 a.m.

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H. The Coroner's report revealed evidence of viral upper and lower respiratory tract infection with inflammation consistent with RSV. The autopsy listed the Cause of Death as "upper and lower respiratory tract infection, days, due to respiratory syncytial [RSV], days."

9. Respondent, Damodara Rajasekhar, M.D., is further subject to disciplinary action for unprofessional conduct in that he committed acts or omissions constituting incompetence in violation of section 2234(d) of the Code in that:

A. Respondent failed to timely diagnose and treat moderate to severe RSV bronchiolitis in an infant.

B. Respondent failed to monitor the respiratory rate of an infant who presented on numerous occasions, with a persistent cough.

C. On or about February 3, 1999, respondent failed to order pulse oxymetry on an infant he suspected to be suffering from RSV.

D. Respondent stated at his Medical Board interview that "rhonchi" is synonymous with "wheezing."

E. Respondent is unsure as to what medications he prescribed to the patient on February 3, 1999.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent, Damodara Rajasekhar, M.D., is further subject to disciplinary action for unprofessional conduct in that he committed repeated negligent acts in violation of section 2234(c) of the Code in that:

Patient Desiree D.

A. Respondent failed to recognize signs and symptoms of infant abuse in a four-month-old patient who presented with multiple unexplained bruises, hoarse voice and weight loss in spite of reports she was "feeding well." As a result of said failure, Child Protective Services was not notified the patient was the victim of abuse.

B. On the visit on or about March 4, 1999, respondent failed to obtain a thorough history on a four-month-old patient who presented with bruises on the cheeks and forehead, hoarse voice and weight loss despite reports the patient was "feeding well."

C. On the visit on or about March 4, 1999, respondent failed to perform a thorough physical examination on a four-month-old patient with complaints of bruises, hoarse voice and loss of weight in spite of reports the patient was "feeding well."

D. On the visit on or about March 4, 1999, respondent prescribed Amoxil to treat "erythematous throat" in a four-month-old patient.

E. On the visit on or March 4, 1999, respondent failed to note the patient had bruises on the forehead and on both cheeks.

F. On the visit on or about March 4, 1999, respondent failed to note he examined the patient's abdomen.

G. Respondent failed to observe any evidence of the fractures or the injuries to the baby at the visits in February and March, although the autopsy and x-rays demonstrated that many of those injuries would have been present when respondent was examining the baby.

H. Respondent failed to be aware that the patient was at an increased risk of child abuse because she had been born methamphetamine-positive, her mother had been drug-positive at the delivery, there had been no prenatal care and the baby was living with her mother and non-maternal boyfriend.

I. Respondent failed to reconcile his March 4, 1999, note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

Patient Kristin S.

J. Respondent failed to timely diagnose and treat moderate to severe RSV bronchiolitis in an infant.

K. Respondent failed to monitor the respiratory rate of an infant patient who presented on numerous occasions, with a persistent cough.

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L. On or about February 3, 1999, respondent failed to order pulse oxymetry on an infant patient he suspected to be suffering from RSV.

M. On or about February 3, 1999, respondent failed to notify the patient's parents about the positive RSV test result.

N. Respondent stated at his Medical Board interview that "rhonchi" is synonymous with "wheezing."

O. Respondent admits that he is unsure as to whether or not he prescribed Ventolin to the infant.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

11. Respondent Damodara Rajasekhar, M.D., is subject to disciplinary action in that he failed to maintain adequate records in violation of Code section 2266, in connection with his care and treatment of the patients in that:

A. Complainant reallegaes paragraphs 5 through 11 above and incorporates them by reference herein.

Desiree D.

B. Respondent failed to chart the location of all of the bruises on patient Desiree D. on March 4, 1999.

C. Respondent failed to chart on March 4, 1999, that Desiree D.'s care givers gave conflicting versions of how the injury to Desiree's D.'s face had occurred.

D. Respondent failed to chart on March 4, 1999, that he would monitor her situation in order to follow up on the concerns of his Medical Assistant.

E. Respondent failed to reconcile his March 9, 1999, note of "bruised cheek" with his medical assistant's note of "bruised cheeks."

Krisitn S.

F. Respondent charted he had prescribed "Ventolin ½ tsp tid 5 days," when, in fact, he is unsure as to whether or not he prescribed that medication to the infant.

SIXTH CAUSE FOR DISCIPLINE

(Dishonesty)

12. Respondent is subject to disciplinary action for unprofessional conduct in that he was dishonest in the documentation of his care and treatment of these patients in violation of Code section 2234(e) as follows:

Desiree D.

A. Respondent falsely stated at his Medical Board interview that his Medical Assistant had not told him that the care givers gave her different versions of how the bruising had occurred.

B. Respondent falsely stated at his Medical Board interview that his Medical Assistant had not told him anything about the patient until after the care givers had left his office.

C. Respondent falsely stated at his Medical Board interview that he only observed one bruise on the child when, in fact, she had three bruises.

Kristin S.

D. Respondent created false medical records regarding his care and treatment in that he falsely charted that he had prescribed Ventolin to Kristin S. when, in fact, he had not.

E. Respondent falsely stated at his Medical Board interview that he had prescribed Ventolin to Kristin S. when, in fact, he had not.

F. Respondent falsely stated at his Medical Board interview that he did not know that the patient's parents were smokers, when, in fact, he did.

G. Respondent falsely testified at the hearing during direct examination that he did not know that the patient's parents were smokers, when, in fact, he did. On cross examination when confronted with the chart of Kristin S' brother, that respondent produced at the hearing, who was also treated on February 3, 1999, respondent recanted his testimony and admitted, for the first time, that he was aware that the parents smoked and he had clearly documented his knowledge of the smoking in that chart.

H. Respondent allowed his expert to falsely testify that respondent did not know that the patient's parents were smokers, when, in fact, respondent did know.

SEVENTH CAUSE FOR DISCIPLINE

(False Records)

13. Respondent is subject to disciplinary action for unprofessional conduct in violation of Code section 2261 in that he knowingly made or signed a certificate or other document directly or indirectly related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts in his care and treatment of Kristin S. in that he charted that he had prescribed her Ventolin when, in fact, he had not, as more fully set forth above in paragraph 8.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 55917, issued to Damodara Rajasekhar, M.D.;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants pursuant to Code section 3527;

3. Ordering, Damodara Rajasekhar pay the Medical Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and,

4. Taking such other and further action as the Medical Board of California deems necessary and proper.

DATED: August 26, 2003.

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant